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after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	moval.	leal examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR
ID THE HUSPITAL UR ALLENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

									95	20501
FOR 1 _ STATE	STATE OF MAR						IENTAL HY	GIENE		
REGISTRAR		CER	TIFICA	TE OF	DEATH	Η	RE	G. NO.		- A
1. DECEDENT'S NAME (First, Middle, Last)	Noush	atu					2. DATE OF DE	DAY	YEAR	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER	5. SEX 6. A	GE (In yral lest bir	rthday) IF U	NDER 1 YEAR	IF UNDER 24	HRS.	7. DATE OF BIE		95 8. BIRTNE	PLACE (State or Foreign
220-07-2250	1 M 2 M F	5	YRS.	THS DAYS	HOURS	MIN.	(Month, Day, Feb. 18		Country	Ohio
9a. FACILITY NAME (If not institution, give str			9b.	CITY, TOWN	OR LOCATION				COUNTY OF DE	ATN
Northwest Hospital	LCenter			Ran	dalls	town	n		Baltin	nore
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10	Oc. CITY, TO	WN OR LOCA	TION					10d. INSIDE CITY
Maryland A	Anne Arund	e ī			Anna	no1 i	ic		1	LIMITS?
10e. STREET AND NUMBER				10	. ZIP CODE	POLI		10g.		HAT COUNTRY?
1008 Park Avenue					2140	3-23	323	Un	nited S	States
11. MARITAL STATUS	12. WAS DECEDENT EV FORCES? 1 1	ER IN U.S. ARMED	D	13. WAS DEC	ENDENT OF	HISPANIC	C ORIGIN? (Spe , Puerto Rican,	city Yea or No-	- 14. RACE	- American Indian, White, etc.
1 Never Married 2 Married Nover Married 2 Married Divorced	IF YES, GIVE WAR	R DATES			2 X NO			•10.)	Specify	
15. DECEDENT'S EDUCA	ATION	18a. DECED	ENT'S USUA	L OCCUPATI	ON		16h KIND	OF BUSINESS		astall
(Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4 or 5 +)	(Give k	kind of work d NOT use retir	one durina me	est of working		Total Tanto	01 800111233	WOOSTAT	
llth		Income	e Tax				Stat	e of M	lary1ar	nd
17. FATHER'S NAME (First, Middle, Last)					18. MOTNES	R'S NAM	E (First, Middle,	Maiden Surnam	e)	
	ewis H. V	Veston						Erni		
19a. INFORMANT'S NAME (Type/Print) Miss Isabel Marie	Moston						oute Number, City			
			-			ltin	nore,MD			
20a. METNOD OF DISPOSITION **XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	val from Stata	20b. PLACE AND Cometary Cramato HIIICT	ory or other places to Me	eca) Moria	imeol 1 Gard	dens	7/8/9	5 Anna	- City or Tow	Maryland
21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE)			22. NAME A	ND ADDRESS	OF FACE	LITY			
b Goseph J. (1	1. K. 00	nnh/	/				uneral			
23. PART i. Entar the diseases, or co	emplications that car	and the death	. Do not e	O / ZO	Liberi	Ly K	as cardiac n	allsto	wn,MD	21133-4784 Approximate
ahock, or haart fallure. LIMMEDIATE CAUSE (Final	ist Dnly Dna cause o	n aach line.				,,		говрасыну	arroat,	Interval Between Onset and Death
disease or condition	COMAGO	too, ho	not.	Inilu.	20.					Oliset and Death
resulting in death)	DUE TO (OR	AS A CONSEQUE	NCE OF):	<u> </u>						
Sequentially list conditions,	Myx	ardial	1 in	Paret	ion					
if any, leading to immediate	DUE TO OR	AS A CONSEQUE	NCE OF):	1	3 175					
CAUSE (Disease or Injury	DUE TO YOR	A DANSEOUE	WILL OFF	1 and	all					
that initiated events reaulting in death) LAST		U	The state of							i
_ d.										1
PART II. Other algnificant conditions	A	4	iting in the	underlyln	g cause giv	en in P		MAS AN AUTOPS		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
munal pawe 10	eplacemen	U					_ 10	YES 2 NO		COMPLETION DF CAUSE OF DEATH?
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES MO UNCERTAIN						1 TES 2 NO				
25. WAS CASE REFERRED TO MEDICAL	IBUTE TO CAUSE	26. PLACE O			UNCER	RTAIN				
	HOSPITAL:		ОТІ	IER:						
27. MANNER OF DEATN 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY					The 5 ☐ Residence 8 ☐ Other (Specify) JURY AT 28d. DE\$CRIBE HOW INJURY OCCURED					
1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Ye	ar)	YRULMI	4 1 🗆	RK? YES 2 . A					- 1
3 Suicide 8 Could not be	28e. PLACE OF INJ building, etc. (URY — At home,	ferm, street,	factory, offic		-	281. LOCATION	(Street and Num	nber or Rural Ro	oute Number,
4 Nomicide determined							City or Town	, state)		
	AN: To the best of my k									
one) 2 MEDICAL EXAMINER: On the basic of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER	29b. SIGNATURE AND TUTLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)									
(P) 03/07/05 028462 5ul 3/5/95						195				

Center

Hospital

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

J BOSTON NORTHWEST HOS

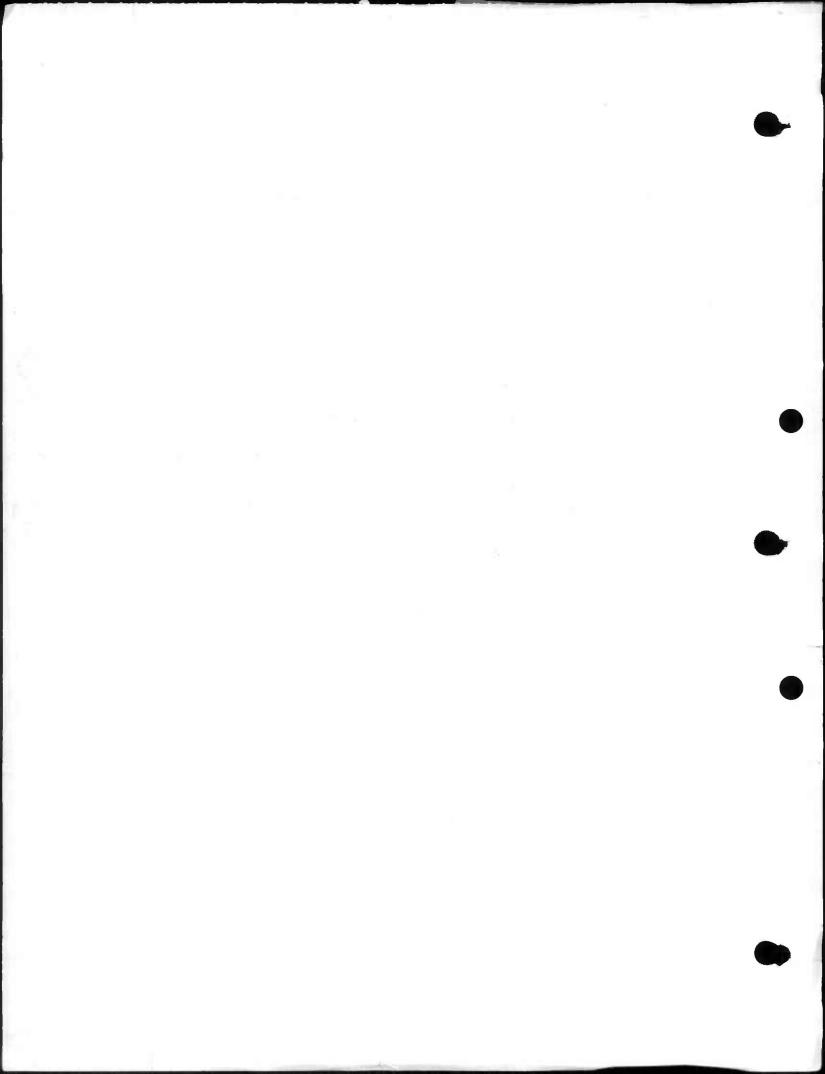
31. DATE FILED (Month, Day, Year)

JUL 0 7 1995 Falls Discourse Completed Cause of Death (ITEM 27) (Type, Print)

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31. DATE FILED (Month, Day, Year)

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2	The state of
2 20	PHYSICIAN:
DIVISION OF VITAL RECORDS, P.O. BOA 86780,	TAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after de
	S
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NURMEET 31. DATE FILED (Month, Day

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SAWHNE

32. REGISTRAR'S SIGNATURE

ed within an nouns after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 he filled within 72 hours after death with the State Deor, of Heath and Mental Horiere prior to burial, cremation, or removal.	event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within zer hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the itse fleed within 72 hours after death with the State Deut of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

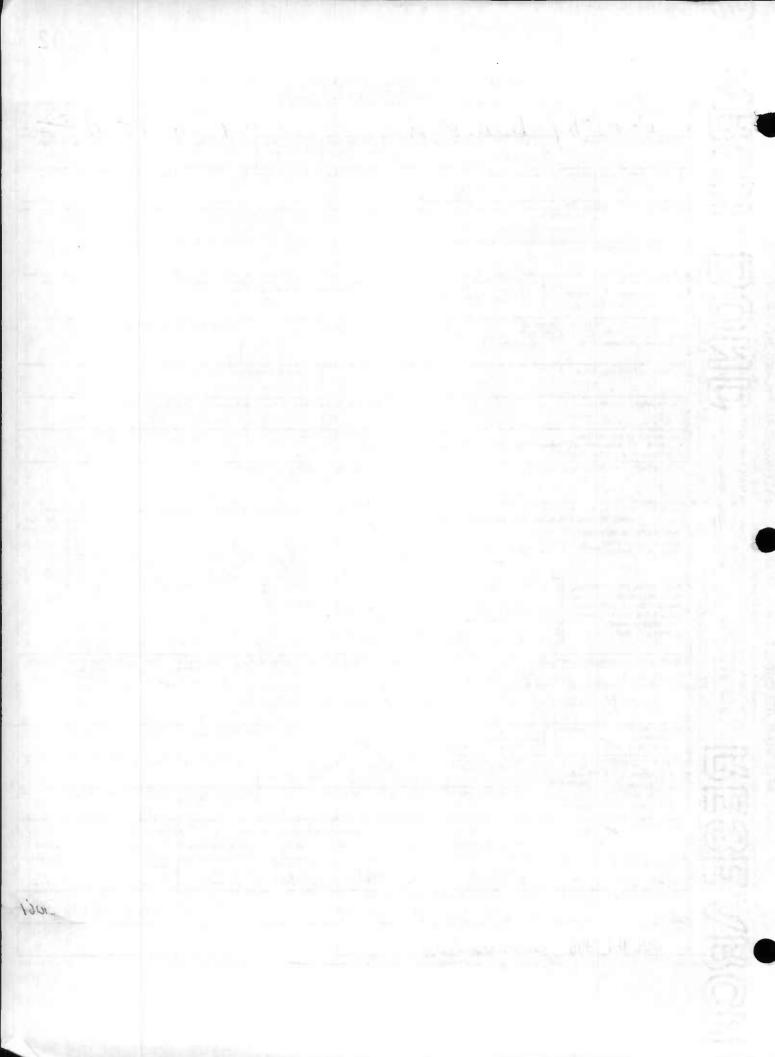
1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 9 S 0001 A. Ah 8. BIRTHPLACE (State or Foreign Country) 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. DAY 1 M 2 F 213-20-9768 83 JUNE 18, 1912 MARYLAND 9a. FACILITY NAME (If not institution, give atreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR NORTH ARUNDEL CONVALESCENT CENTER GLEN BURNIE ANNE ARUNDEL RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND ANNE ARUNDEL GLEN BURNIE 1 YES 2 NO FUNERAL 10a. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 219 SHANA DRIVE 21060 UNITED STATES 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuben, Maxican, Puerlo Rican, etc.)

1 YES 2 NO Specify: Specify: WHITE IF YES, GIVE WAR OR DATES BY 3 🔀 Widowed 4 🗌 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY ndary (0-12) College (1-4 or 5+) 12 SECRETARY MARYLAND STATE GOVERNMENT 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) HARRY L. HIGGINS IDA L. MOORE BE 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 219 SHANA DRIVE, GLEN BURNIE, MARYLAND 21060 JAMES E. DUNIVIN 20a. METHOD OF DISPOSITION

↑ Burlal 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of JULY 7, DATE 20c. LOCATION - City or Town, State MEADOWRIDGE MEM. PK. 1995 4 Donation 5 Other (Specify) ELKRIDGE, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY KIRKLEY-RUDDICK FUNERAL HOME 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, Approximata shock, or heart failure. List only one cause on each lina. Interval Batween Onset and Death IMMEDIATE CAUSE (Final disease or condition arction Myocardial tcute 10 min resulting in death) overe 40ar Coronar CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate in larcti cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST NO PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AMAILABLE PRIOR TO 97 COMPLETION OF CAUSE 1 | YES 2 1 NO th 09 VB 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28_PIFACE DF DEATH (Check only one) HOSPITAL OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) 1 | YES 2 19 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 ND BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide determined 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 206 SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Pay, Year)

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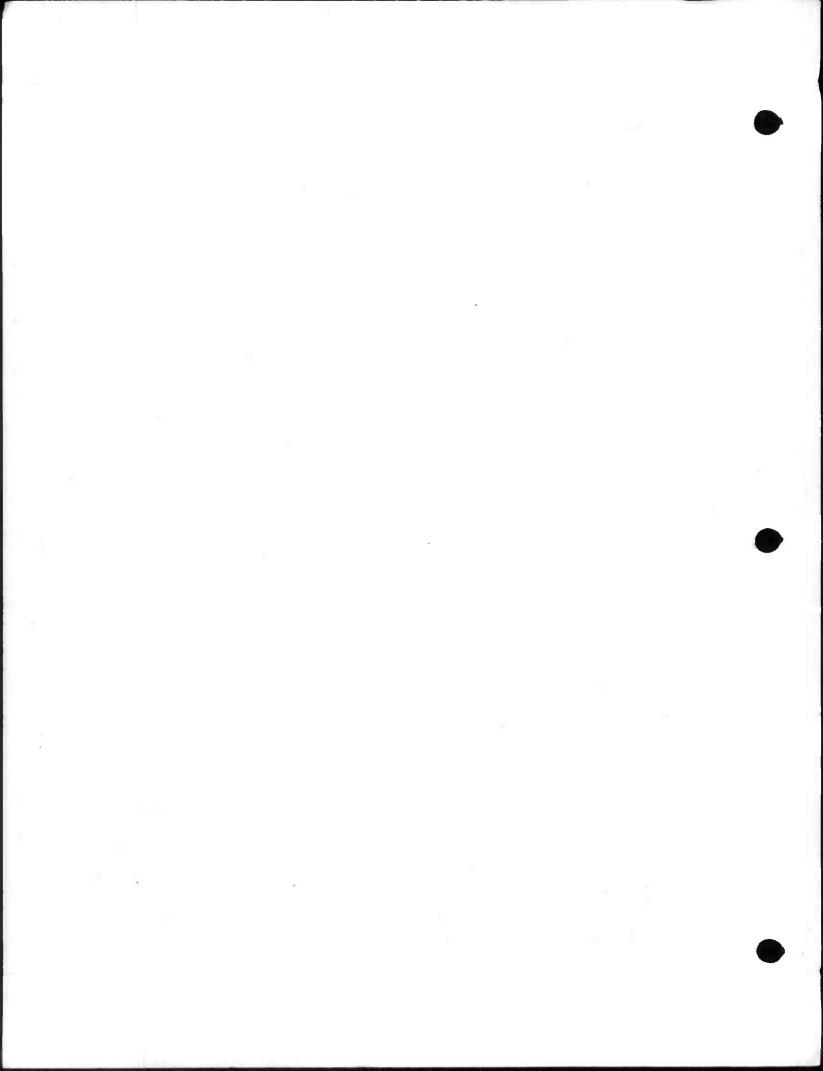
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FUNERAL DIRECTOR	RESIDENCE OF DECEDENT	5. SEX 1 M 2 M F 44 street and number)	DeSAN	DIES		2. DATE OF DEATH MONTH D	AY Y	3. TIME OF DEATH		
RAL DIRE	4. SOCIAL SECURITY NUMBER 054-42-4373 9a. FACILITY NAME (If not institution, give GOOD SAMARITAL RESIDENCE OF DECEMENT	5. SEX 6. AGE 1 1 M 2 X F 444	(In yrs. last birthday)	DIES		and tarii				
RAL DIRE	9a. FACILITY NAME (If not institution, give GOOD SAMARITAI RESIDENCE OF DECEMENT	1 M 2 K F 444				JULY 0	4 199			
RAL DIRE	GOOD SAMARITAN	street and number)	YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)		
RAL DIRE	RESIDENCE OF DECEDENT		1113.	9b. CITY, TOWN (OR LOCATION OF DE	<u>JAN 09,195</u> ATH	9c. COUNTY	New York		
RAL DIRE		GOOD SAMARITAN HOSPITAL BALTIMORE CITY N/A								
PAL								10d. INSIDE CITY		
NERAL	Maryland N/A		Baltimore				1 XYES 2 NO			
2 II	732 Cold Spring		101	1. ZIP CODE 21212		10g. CITIZEN OF WHAT COUNTRY? USA				
5	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS DEC		IC ORIGIN? (Specify Yes		RACE - American Indian.		
B⊀	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES		If yes, sp	ecify Cuban, Maxica 2 NO Specify	, Puerto Rican, etc.)		Black, White, atc. Specify: Black		
ETED	15. DECEDENT'S EDI (Specify only highest grad		16a. DECEOENT'S I	rork done during mo		16b. KIND OF BU	SINESS/INDUS			
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+	Dir of	,	Youth Cont	er State o	of Nov	Vork		
COMPL	17. FATHER'S NAME (First, Middle, Last)		DII. OI	I CHILLY 1		ME (First, Middle, Maiden		TOLK		
H		in DeSandies			Gloria Barbara Pierre					
<u>و</u> ا	19a. INFORMANT'S NAME (Type/Print)	oCondias				loute Number, City or Tow				
-	Gloria Barbara D	20h	PLACE AND DATE O	EDISPOSITION /No	ame of	altimore,		or Town, State		
- 10-	1 Burial X Cremation 3 Rar 4 Donation 5 Other (Specify)	noval from State	tro Crematory or off	atory, I	Inc. 07/0	7/95 Ba	altimor			
	21. SIGNATURE OF FUNERAL SERVICE L	Comala	Donald	Crema	ation Soc		ryland	l, Inc.		
CERTIFICATION	IMMEDIATE CAUSE (Finel disease or condition reaulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Onset and Dae Onset and Dae Onset and Dae									
	PART II. Other algnificant condition	ne contributing to death b	ut not resulting in	n the underlying	g ceuse given in i	Part i. 24a. WAS AN PERFOR	MED?	24b, WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
	DID TOBACCO USE CONT				UNCERTAIN					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXYES 2 NO	HOSPITAL: 1 Inpetient 2 XER/Outp		OTHER:	ie 5 🗆 Rasidence	8 ☐ Other (Specify)				
	27. MANNER OF DEATH 1 Natural 5 Pending	(Month, Day, Year)	26b. TIME INJU	JRY WO	RK?	28d. DESCRIBE HOW I	NJURY OCCUR	ED A STO		
B	2 Accident Investigation	reet, factory, office	1 VES 2 NO SUNSTAND NOW NAT VIOLENT DROWN NUMBER, OH TO VIOLENT NU							
ETED	4 Homicide 6 Could not be determined	building, atc. (Spec	offy)	BATH		City or Town, State)		"BATTHONE		
COMPLE	one)	ER: On the beat of axamination				to the cause(a) and men	mer so stated.			
	2915 SIGNATURE AND TITLE OF CERTIFIE				29c. LICENSE NUM			GNEO (Month, Day, Year)		
2	Would the	tale			O.C.M.			LY 05, 1995		
	OF NAME AND ADDRESS OF PERSON WI									
	31. DATE FILED (Month, Day, Year)	KORELLYM:		n Stree	et, Bal	timore, M	Maryla	and 21201		

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

	Pages		
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	id completely filled in by the funeral director, page 5 should be detached for use as the bus	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once

1, 2, 3 should

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR 1995 Katie Delong 30 0200 Darlene June 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year SEPT 6. AGE (In yrs, last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTNPLACE (State or Foreign T BROOK, IN 220-21-5014 DAYS HOURS 1 M 2 M F Sa. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Fairgrounds Road Springhill Charles 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 YES 2 NO DOKF FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 20602 11.5. 11. MARITAL STATUS
1 Nover Married 2 Married
3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ABMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No. If yes, specify Cuben, Maxican, Puerto Rican, stc.)

1 YES 2 NO Specify: BY ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 166. KIND OF BUSINESS/INDUSTRY (Specify only highes) dary (0-12) College (1-4 or 5+) COMPL UNEMDLO VED 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) AIS ELONG BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS /S/ State, Zip Code) 2 RAIG 1607 20s, METHOD OF DISPOSITION

1 Buriel 2 Cremation 3 Re DATE 4 ☐ Donation 8 ☐ Other (Specify) 21. SIGNATURE OF PANERAL SERVICE LICENSEE 10 ス 1224 23. PART I. Enter the diseeses, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Approximats** shock, or heert felidre. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death MULTIPLE disesse or condition 12 TUPLES resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, lesding to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 | NO 1 NES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES ☐ NO ☐ UNCERTAIN ☐ 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) EXAMINER? HOSPITAL OTHER: * Yother (Specify) at scene ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 4 - Nursing Nome 5 - Residence 27. MANNER OF DEATH 28e. DATE OF INJURY 286. TIME OF INJURY 033 AM 28d. DESCRIBE NOW INJURY OCCURED 28c. INJURY AT WORK? 6 30 95 1 Natural 1 YES 2 NO OCCUPANT OF BY 2 Accident 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide determined STREET PAIRGROUND SPRINGHILL MI 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and manner ea stated. (Check only one) nd/or Investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 2 M.E June 30 1995 PRIN WHO COMPLETED CAUSE OF DEATH STEM 27) (Type, Print)

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111 Penn Street, Baltimore,

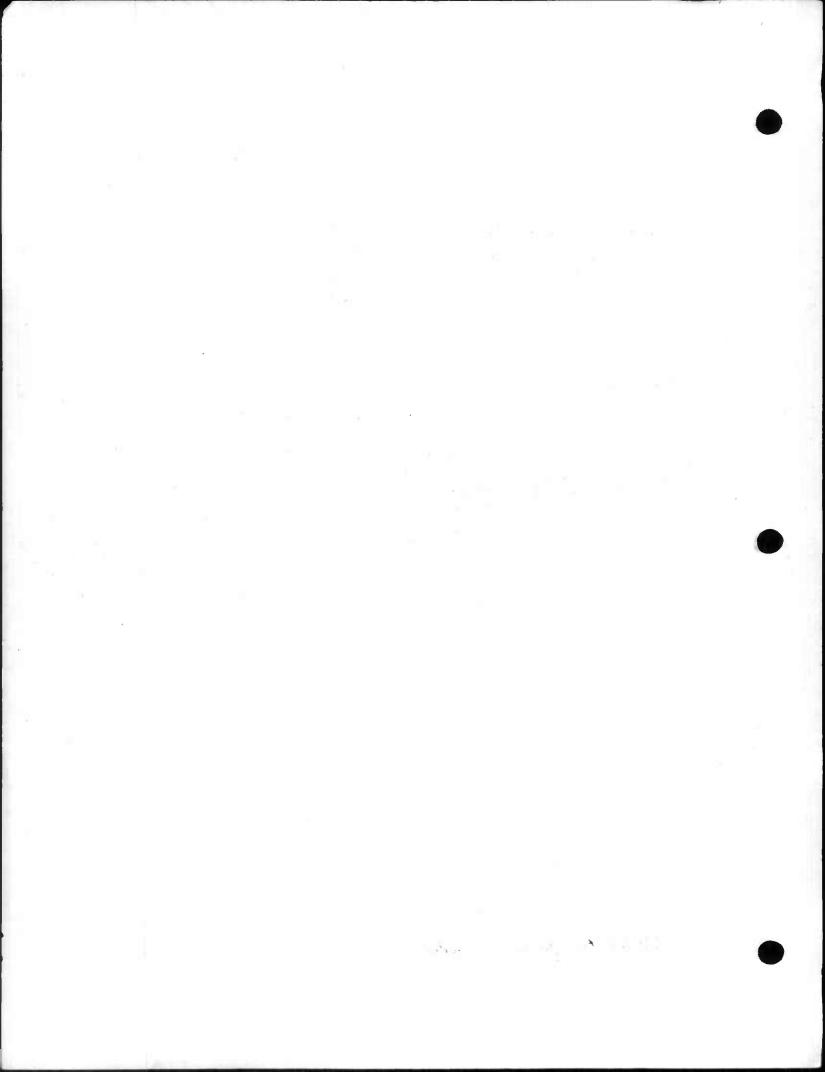
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the float that death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and computing flind in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPART	MENT OF H	HEALTH AND	MENTAL HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	-	3. TIME OF DEATH
	JOSEPH G. DE LA FE					JUNE 30, 1995	YEAR	9:53 P. M
			The second secon	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	Cour	THPLACE (State or Foreign intry)
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0	9a. FACILITY NAME (If not institution, give stre		9		OR LOCATION OF D	EATH	9c. COUNTY OF	DEATH
DIRECTOR	HOWARD COUNTY GENERAL	HOSPITAL		COLUME	BIA		HOWA	ARD
l m	10e. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCA	TION			10d, INSIDE CITY
5	MARYLAND ANNE	ARUNDEL		LAUREL				LIMITS?
AL	10e. STREET AND NUMBER			10	. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?
FUNERAL	3379 STYLE AVENUE				20724		į	JSA
1 2	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 X YES		13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specify Yee o	r No 14, RA	CE — American Indian, ack, White, etc.
₽	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA			2 NO Specif			ectly: WHITE
	15. DECEDENT'S EDUCA	TION	16a. DECEDENT'S US	UAL OCCUPATION	ON	16b. KIND OF BUSIN	FSS/INDLISTBY	
Ē	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of wor life. Do NOT use i	k done during me	ast of working	100 7440 07 000		
절	12 Ø		SUPERVISO)R		STATE GOV	VERNMENT	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maiden Su	irname)	
BE	JUAN DE LA FE				EULALIA (GONZALES		
2	19e. INFORMANT'S NAME (Type/Print)					Route Number, City or Town,		
	RAMONA M. DE LA FE					MARYLAND 2072		
	1)(X) Buriel 2 Cremation 3 Remov	rel from State 20b.1	PLACE AND DATE OF tery, cramatory or other MARY S CAT	DISPOSITION (Na	ame of	i .	TION — City or	
1	21. SIGNATURE OF FUNERAL SERVICE LICE		MARY'S CA		NO ADDRESS OF FA	OH ITTY	OLIS, MA	
	A Parto	d Chaha				FLECK FUI	NERAL HON	ME, INC.
\vdash	or number of the state of	wavy					-	4ND 20707
	23. PART I Enter the diseases, or co shock, or heart fallure. Li	at only one cause on ea	the death. Do not the death.	enter the mo	de of dying, suc	h aa cerdiac or respira	tory arrest,	Approximate interval Between
	IMMEDIATE CAUSE (Final disease or condition	TIMPE	RALE	MIA				Onset and Death
	resulting in death)	DUE TO (OR AS A	CONSEQUENCE OF	1777	1			lady
-		RENI	CONSEQUENCE OF):	FUN	CHON	•		
흔	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEGUENCE OF	-	0000	TATE.		
S	cause. Enter UNDERLYING CAUSE (Disease or Injury	0.1.0		Ot	TROS	11512		
1 1 1	that initiated events resulting in deeth) LAST	DUE TO (OR AS A	CONSEGUENCE OF):					
CERTIFICATION	d.							
AP.	PART ii. Other aignificant conditions	contributing to death bu	t not resulting in	the underlying	g ceuse given in	Part I. 24s. WAS AN AL		1b. WERE AUTOPSY FINDINGS
						PERFORMI	NO	MAJLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDIC								1 YES 2 100
	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YES	□ NO □] UNCERTAII	V D		· ·
HYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	6. PLACE OF DEATH	(Check only one)				
YSI	1 YES 2 DWO	Inpatient 2 ER/Outpa	tient 3 DOA 4	☐ Nursing Hom	e 5 🗆 Residenca	8 Other (Specify)		
F	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME (Y WO	RK?	28d. DESCRIBE HOW INJ	URY OCCURED	
B	2 Accident Investigation	28e. PLACE OF INJURY -	At here to a		rES 2 NO			
	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specif	– At nome, farm, stre y)	et, factory, offic	•	261. LOCATION (Street end City or Town, State)	! Number or Rura	I Floute Number,
COMPLET	29e. CERTIFIER							
MP	(Check only one) 2 MEDICAL EXAMINER:	AN: To the best of my knowle On the bests of examination	dge, death occurred a	nt the time, date	end place, and due	to the cause(a) and manne	ir as stated.	11.000000000000000000000000000000000000
1 - 1	29b. SIGNATURE AND TITLE OF CERTIFIED		arrabor investigation,	in my opinion, o		-		
8	Traux 5	Roser			29c. LICENSE NUI	OUL (Nr.)	9d. DATE SIGNE	(Month, Day, Year)
일	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, Pri	int)	.010	- 1/(10)	· Jul	134170
	-KNOU NO	RTHL, C	Ocute		MID	2104	KS	
	31. DATE FILED (Month, Day, Year) JUL 0 71995	32. PEGISTRAN'S SIGNAT	TURE					
	JOE 0 (1333 7	AN MINISTER OF	TRAS.					



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31. DATE FILED (Month, Day, Year)
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32. REGISTRAR'S SIGNATURE Mindenta

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HYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page	hysician and completely filled in by the funeral director, page 5 shoul	emat	or other traumatic event, the medic
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NO.	. Afte	dea	E 99
TEN	CTOR: After this certificate has been signed by the attending physician	after	200
JR A	MREC	SJDC	E
AL C	AL D	be filed within 72 hours after death with the State Dept. of Health	APORTANT: If Item 28 is marked, or item 23 shows any injury, or other
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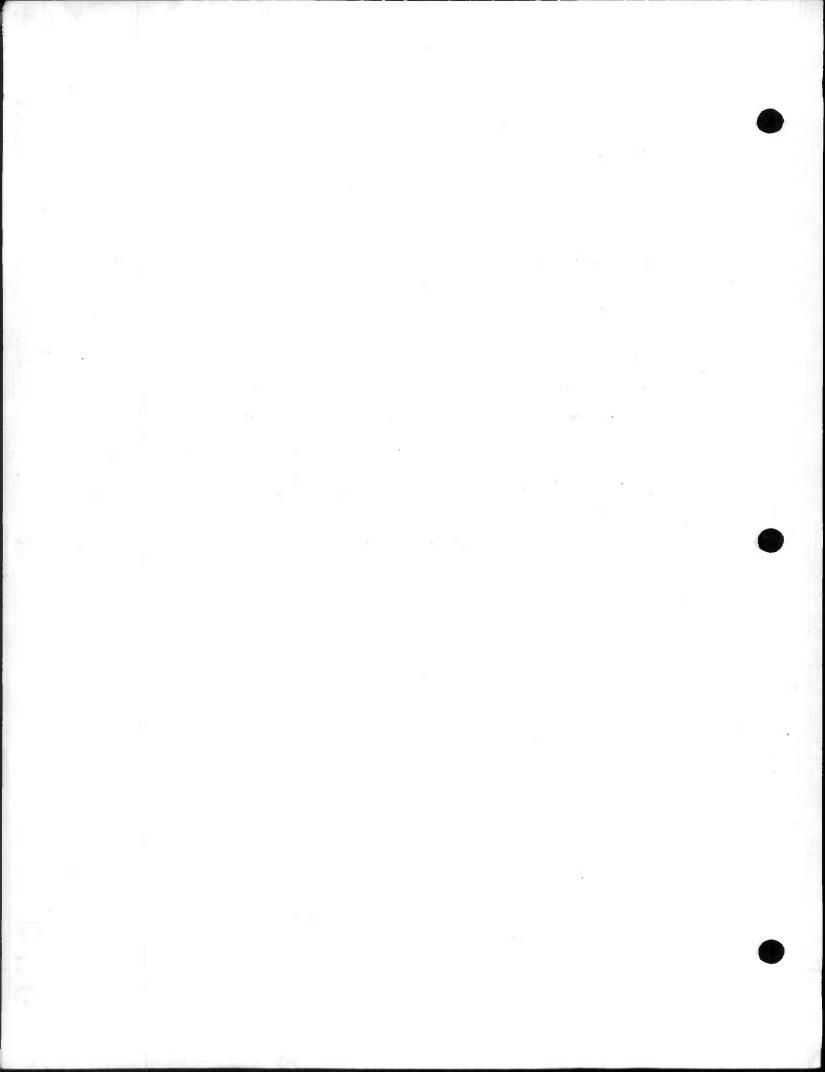
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995" RONALD THURMAN DENNING JULY 7:00 A. 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH DAYS HOURS 1 M 2 | 1 2/25/39 221-24-6787 56 YRS WEST VIRGINIA 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR PERRY HALL BALTIMORE 5124 CLIFFORD ROAD 10h COUNTY 10e. STATE 10c. CITY, TOWN DR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE PERRY HALL 1 YES 2 NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 5124 CLIFFORD ROAD 21128 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yee, specify Cuben, Mexican, Puerto Rican, atc.)

1 YES 2 XNO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Merried 2 Merried BY 3 Widowed 4 Divorced Specify: WHITE 15. DECEDENT'S EDUCATION COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b, KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5 +) 9th GRADE PAINTER JOHNS HOPKINS UNIVERSITY 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) HARRY DENNING MARIE ALFORD BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 LOUISE DENNING 5124 CLIFFORD ROAD PERRY HALL, MD 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE 1 Buriel & Cremation 3 Removal from State METRO CREMATORY, INC. 4 Donation 5 Other (Specify) 7/7/95 CATONSVILLE, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY JOHNSON FUNERAL HOME Mishna 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23. PART I. Enter the diseeses, or complications that ca ed the death. Do not enter the mode of dying, such as cardiec or respiratory errest, Approximata shock, or heart fellure. List only one cause on each line. interval Between **IMMEDIATE CAUSE (Fine) Onset and Death** disease or condition etastahe Lunovir (vain 4 MONTH resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (DR AS A CONSEDUENCE DF): if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEDUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO Se zure desorder COMPLETION DF CAUSE 1 TES 2 NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN M 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) OTHER:
4 | Nursing Home | 5 | Raeldence | 8 | Other (Specify) HOSPITAL: 1 - YES 2 - 40 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME DF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 🔯 Natural м 1 YES 2 ND BΥ Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be COMPLETED 4 Homicide 29e. CERTIFIER (Chack ank) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(e) end manner se stated. 2 MEDICAL EXAMINER: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner as stated, 296. SIGNATURE AND TITUE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER handrasilcharan Nan 21778 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LOCH RAVE

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TO THE HOSPITAL OR ATTENDING DEVOCIDATION The Jan racinities that the death nearly had within 24 hours after doors. E In the control of
of the contract of the contrac
TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director page 5 should be detached for use as the burial-traneit perms 1.2.3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

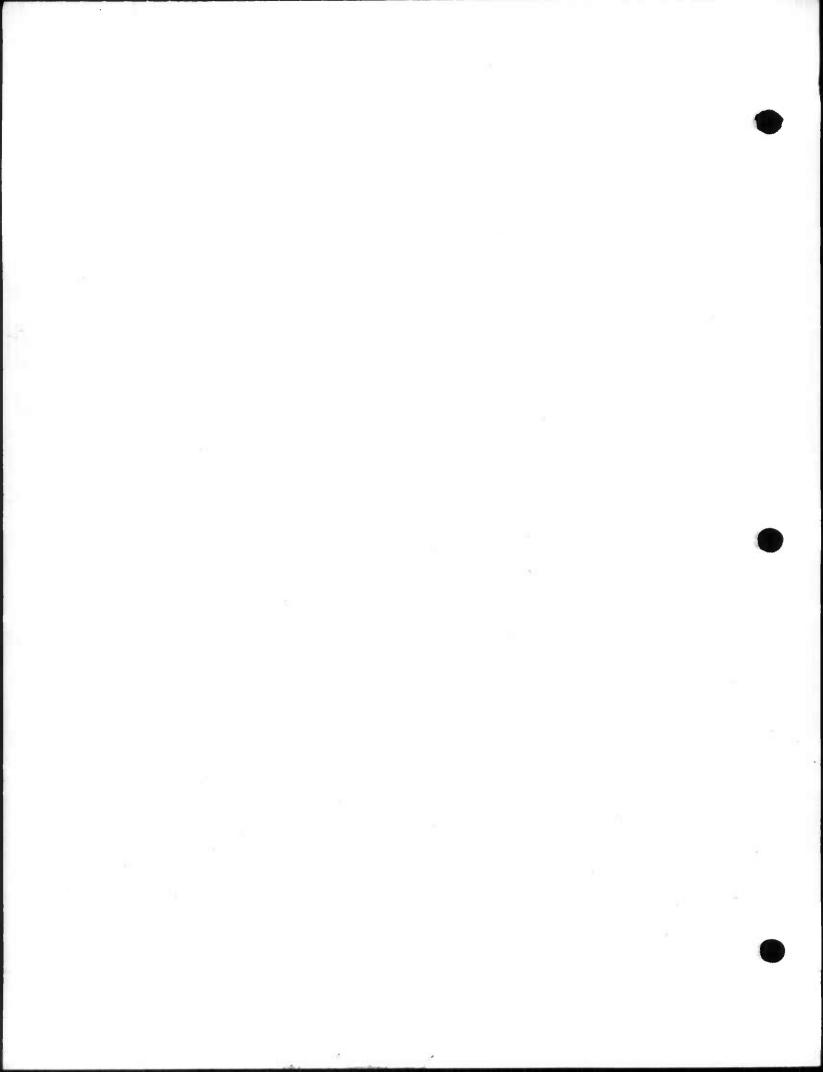
	FOR 1 - STATE REGISTRAR		MARYLAND /			OF H	IEALTH	AND I	MENTAL I	HYGIFN	F	
			CI	ERTIF	ICATE	OF	DEA	TH		REG. NO.		
1	1. DECEDENT'S NAME (First, Middle, Last)	77.0							2. DATE OF MONTH	DA	.,	YEAR 3. TIME OF DEATH
	CLAUDE DANI 4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDER	1 YEAR	IF UNDE	1 24 HRS.	JULY .		95	12:05 P M B. BIRTHPLACE (State or Foreign
	238-36-7848	1 🗆 🗮 2 🗌 F	69	YRS.	MONTHS	DAYS	HOURS	MIN.	FEB.8	lest Year)	; [DURHAM, N.C
	Se. FACILITY NAME (If not institution, give a	reet and number)			9b. CITY	TOWN C	OR LOCATI	ON OF DE		, 1 320		TY OF DEATH
5 R	THE JOHNS HOPKINS HOSPITAL					LTIM	ORE	CITY	7			n/a
DIRECTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY	,		10c. CIT	Y, TOWN C							10d. INSIDE CITY
9	MARYLAND	n/a			BALTIMORE							YIMITS?
FUNERAL	1219 N. MILTON	AVENUE		101. ZIP CODE						109. CITIZEN OF WHAT COUNTRY? UNITED STATES		
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDER FORCES? 1 IF YES, GIVE V	MED IO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee If yee, specify Cuban, Mexican, Puarto Rican, etc.) 1 YES 2 NO Specify:					Specify Yes in, etc.)	or No-	14. RACE — American Indian, Black, White, etc. Specify: BLACK	
田田	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DE	CEDENT'S	USUAL OC work done o	CUPATIO	ON st of workli	ng	16b, Ki	ND OF BUS	INESS/INDU	ALL AHAN
COMPLETED	Elementary/Secondary (0-12) UNKNOWN	College (1-4 or 5	+) #10.			DRI				POTI	CO.	
BE CO	17. FATHER'S NAME (First, Middle, Lest) WILLIAM DAVI	S							ME (First, Midd			1
70	190. INFORMANT'S NAME (Type/Print) RUBEN EDWARD	DANIELS	191	RT.5	BOX	(Street a	nd Number HE	or Rural F	RSON, N	ORTH	CAR(OLINA 27536
	20s. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Remo	oval from State	20b. PLACE / cemetery, cre	matory or o	ther place)				DATE	1		City or Town, State
	4 Donation 5 Other (Specify)	ENSEE /	BAL	TIMOF			ETER'		78	BAL	TIMOR	RE, MARYLAND
	· F -		8						- FH.	1101	E M	ORTH AVENUE
	23. PART I. Enter the disease, or/c	omplications the	t caused the	ath Do								
	shock, or heert feliure. I IMMEDIATE CAUSE (Final	list only one cau	ise on asch lina		Zor amer	- IIIO	de or dy	ing, suci	i es cardisc	or respir	atory srre	Approximate interval Batween Onset and Death
	The state of the s				mina Sepsis							1104
			DUE TO (OR AS A CONSEQUENCE OF :								(4)	
ON O	Sequentisity list conditions, if any, leading to immediate couse. Enter UNDERLYING CAUSE (Disease or injury that initiated events Due to (or as a conscouence of):									Dolays.		
SATI										0 3 hours		
CERTIFICATION	CAUSE (Disease or injury that initiated events				F):	10.1-	-/10	23	791	100	Diric	31100.3
E	resulting in deeth) LAST	ASP	iration	\								14hours
	PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS											
MEDICA	Cerebral Vascular Accident, Coaculo party PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE											
ME	- Malnutrition	Neutra		,				/	_		*	OF DEATH?
PHYSICIAN:	DID TOBACCO USE CONTR	BUTE TO CA					UNC	ERTAIN	1 🗆			
Sic.	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:			OTHER	:						
HYS	27. MANNER OF DEATH	28e. DATE OF	INJURY	DOA 26b. TIM				aldence	6 Other (S)		HIEV OCC	upen
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, D	(Month, Day, Year) INJURY WORK?									
ED B	3 Suicide 8 Could not be	cide 8 Could not be 28s. PLACE OF INJURY — At home, farm, street, factory, office building str. (Sheet) 28s. PLACE OF INJURY — At home, farm, street, factory, office 28s. LOCATION (Street and Number or Rural Route Number,							or Rural Route Number,			
	4 Homicide detarmined City of Town, State)											
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the best of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.											
296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER L9792												
									414 2,1995			
F	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS							(1	e 1	1 ^	
	SUSAN ZIC	MAN	Tower	110	Joh	13	Hop	cin:	s Itos	pita	1 6	Baltmore, MD
	JUL 07 25 Ja	A PHEGISTRA	R'S AGNATURE									

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10 THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. 10 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use 2 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFIC	CATE OF I	DEATH	REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH ANOTH JULY 1, DAY 1995 1:50 A									
			n yrs. last birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		THPLACE (State or Foreign		
	210 02 0122	Ø M 2 □ F 46	. M		HOURS MIN.		1948 Mar	yland		
_	9e. FACILITY NAME (If not institution, give street			b. CITY, TOWN OR			9c. COUNTY OF			
6	Hopkins Bayview Me	edical Cent	er	Bal	timore		N/	'A		
E	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c, CITY,	TOWN OR LOCATIO	N .			104 INCIDE CITY		
DIRECTOR	Maryland	N/A		Balti				10d. INSIDE CITY LIMITS? 1 YES 2 NO		
FUNERAL	100. STREET AND NUMBER 5054 E. Federal S		10f. Z	2120	10g. CITIZEN OF	WHAT COUNTRY?				
5	11. MARITAL STATUS 12.	. WAS DECEDENT EVER IN FORCES? 1 X YES	U.S. ARMED	13. WAS DECEN	NOENT OF HISPAN	IIC ORIGIN? (Specify Yes		E — American Indian,		
B	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DA Vietnam W	TES		NO Specifi	n, Puerto Rican, etc.)	Spe	ck, white, etc. white		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade com	npleted)	16a. DECEDENT'S US (Give kind of wor life. Do NOT use r	k done during most	of working	16b. KIND OF BUS	SINESS/INDUSTRY			
APLE	Elementary/Secondary (0-12) C. 12th Grade	ollege (1-4 or 5 +)	Die Cut	*		Cardboar	d Contai	ner Company		
0	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Maiden				
BE (Joseph Everett				Susann	a T. Gnidzi	nski			
2	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Tow				
-	Brenda Everett (Dau	ghter)	4918 W	ilbur Av	e., Bal	timore, Ma	ryland 2	1205		
	20s, METHOD OF DISPOSITION 1 A Burlel 2 Cremetion 3 Removal 4 Donation 5 Other (Specify)	from State 20b.	PLACE AND DATE OF Stery, crematory or other AR Lawn (DISPOSITION (Name		DATE 20c. LOCATION — City or Town, State				
	21. SIONATURE OF FUNERAL SERVICE LICENS		are Euget C	22. NAME AND	ADDRESS OF FA	CILITY		marycana		
, i	· Math	DGA	*			neral Home Lane, Balt		ld 01012		
	23. PART I. Enter tha diseeses, or com	plications that ceused	the deeth. Do not	enter the mode	of dying, suc	h sa cardiac or respi	ratory srrest,	Approximata		
- 1	shock, or heart fellure. List	only one cause on as	ch lina.	1				Interval Between Onset and Death		
		Respirate	NI CAME	st 2	9			Chiset sho beath		
	resulting in death) s	DUE TO (OR AS A	COMPEQUENCE OF			, 1	Α	1		
z		Myterstai	Ku to	ngrlau	CAZ	Lymn has	rother	spread.		
일	Sequantially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):			0	7 4 10	3/01		
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disesse or Injury									
E I	that initieted events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):							
H	d									
	PART II. Other significent conditions co	ontributing to deeth bu	it not resulting in	the underlying o	ceuse given in	Pert i. 24a. WAS AN	AUTOPSY 24	b. WERE AUTOPSY FINDINGS		
EDICAL						PERFOR		AMILABLE PRIOR TO COMPLETION OF CAUSE		
				/		1 YES 2	ap-mo	DF DEATH?		
Ξ .	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		6. PLACE OF DEATH		OTTO STORY					
Sic		OSPITAL: Inpetient 2 - ER/Outpe		THER:	5 Residence	8 Other (Specify)				
ΞI	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME C	F 28c. INJUR	Y AT	28d. DESCRIBE HOW II	JURY OCCURED			
	1 Natural 5 Pending	(Month, Day, Year)	INJUR		(? B 2 □ NO					
₽¥	2 Calette	28e. PLACE OF INJURY	At home, farm, stre	et, factory, office		281, LOCATION (Street a	nd Number or Rural	Route Number,		
COMPLETED	4 Homicide determined									
7	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN	nor so stated								
8	one) 2 MEDICAL EXAMINER: O		e) end menner ee stated.							
	290: SIGNATURE AND TITLE OF CERTIFUR									
29c. LICENSE NUMBER 29d. DATE SIGNED (Month). 29d. DATE SIGNED (Month).										
										Paul J-Christ
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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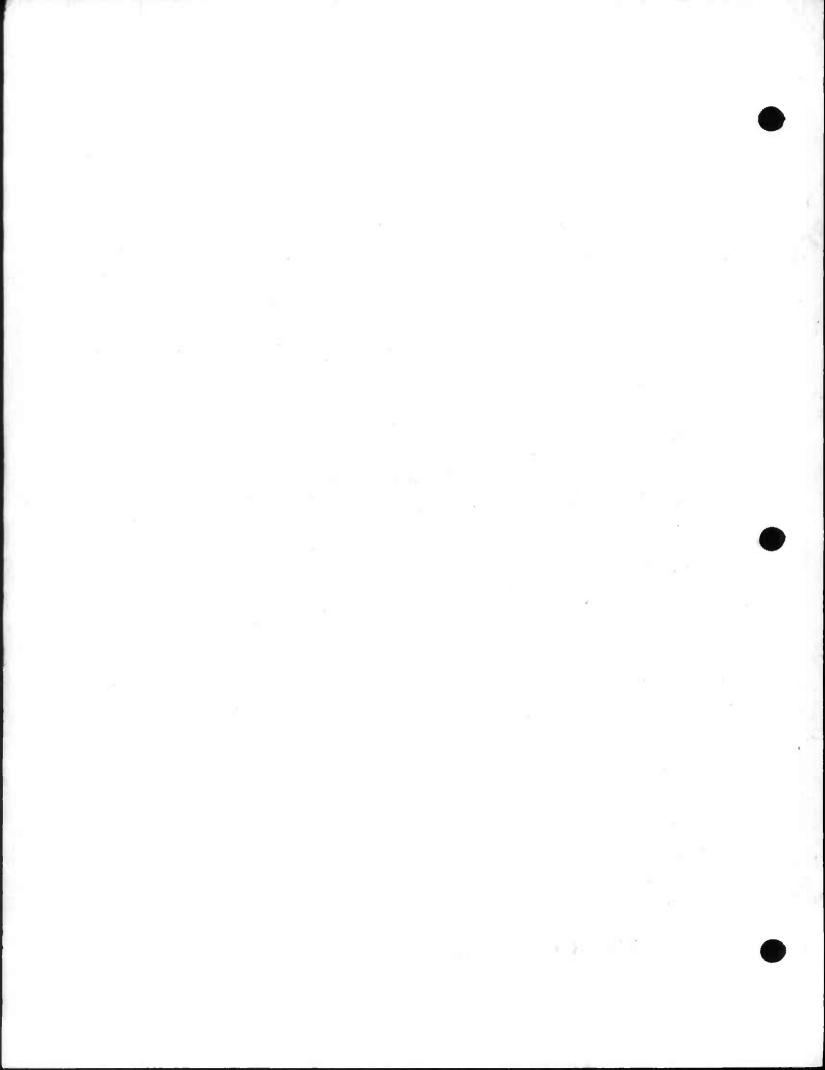
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hyghere prior to burial, cremation, or removal. IN I item 28 is marked, or item 23 shows any influry, or other traumatic event. The medical examiner must be notified at once.

FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR CERTIFICATE OF DEATH REG. NO.
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE DF DEATH 3. TIME OF DEATH
	Johnnie Erving July 5 1995 3:57 AM
	4. SOCIAL SECURITY NUMBER 5. SEX Do. AGE (In yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPI ACE (State of Foreign
	224-34-0565 1XM 2 0 F 68 YRS. MONTHS DAYS HOURS MIN. (Month, Day, Year) (926 Country) VA
	90. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH
H	Sinai Apsoital Bulton NA
DIRECTOR	RESIDENCE OF DECEDENT
H	10a. STATE 10b. COUNTY 10c. CITY TOWN OR LOCATION 10d. INSIDE CITY LIMITS?
	Dalto JUMITS?
AL	10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY?
EB	5123 Hrbutus Hue 21215 U.S.A
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No. 14. RACE - American Indian.
	1 Never Merried 2 Merried Black, White, atc. FORCES? 1 YES 2 NO If yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, atc. Specify: Specify: Specify:
ВУ	3 Wildowed 4 Divorced 2-16-43 thru 2-13-46
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Silve kind of work done during most of working) 16b. KIND OF BUSINESS/INDUSTRY
	Elementary/Secondary (0-12) College (1-6 or 5+)
MP	12 NA Machine Operator Taper Company
COMPLETED	17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)
BE (Lynn Hochy Man Erving
TO B	19e. INFORMANT'S NAME (TypedPhint) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ř	Thelia Hanna 2560 Harlem Ave Balto, and 21216
	200 METHOD OF DISPOSITION 200. PLACE AND DATE OF DISPOSITION Name of DATE 20c. LOCATION — City or Town, State
	Donellon 8 Other (Specify)
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
	March F. H- West
_	4300 Wabash Ave
	23. PART Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, abock, or hear fullure. List only one cause on each line.
	With the pathodi
	resulting in death) a. Post obstructive Preumonia
	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. POST OBST/ACTIVE PREUMONIA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF):
Z	Sequentielly list conditions, Squamous cell Carcinona of Lung
CERTIFICATION	if any, leading to immediate
2	CAUSE (Disease or injury
#	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST
E	d.
0	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINOINGS
DICAL	PERFORMED? AVAILABLE PRIOR TO
	1 U YES 2 NO COMPLETION OF CAUSE OF DEATH?
M	1 TYES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN
ᅙ	25. WAS CASE REFERRED TO MEDICAL EXAMINER? MOSPITAL: OTHER:
YS	1 YES 2 O NO 11 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)
표	27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF NJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED
Β¥	1 Natural 5 Pending M 1 YES 2 NO
	3 Suicide 6 Could not be 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28s. LOCATION (Street and Number or Rural Route Number, City or Town, State)
	4 Homicide determined
الة	29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as attated.
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
	THE REPORT AND THE OF PERSONS
H	290. WHE STONE HOMBER
	AS2402321-GS 9944 July 5 1995
2	30. NAME AND APPRESS OF PERSON WHO COMPLETED CAUSE DE DEATH (TEM AT) (Tem Office)
Ĕ	Singi Hospital 2401 Belvedere Avenue Battimure Mp 21215
Ţ	30. NAME AND APPRESS OF PERSON WHO COMPLETED CAUSE DE DEATH (TEM AT) (Tem Office)

DHMH-16 Rev 1/89



Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HE. CERTIFICATE OF D		AL HYGIENE REG. NO.	120010					
	1. DECEDENT'S NAME (First, Middle, Last) SHIRLEY E. FRAMPTON	2. DA		YEAR 10 20 M					
	2/9-28-1396 1 M 2 XF 63 YRS. MONTHS DAYS H	ours Min. Fe	15,28,1932	B. BIRTHPLACE (State or Foreign Country)					
TOR	96. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR RESIDENCE OF DECEDENT 96. CITY, TOWN OR BA III	MOLE	9c. COUNT	9c. COUNTY OF DEATH N/A					
DIRECTOR	MD. 106. COUNTY BALT, MO			10d. INSIDE CITY LIMITS? 1 YES 2 NO					
FUNERAL	927 S. STREEPEL ST.	21224	U.	S.A.					
D BY FL	1 Never Married 2 Married FORCES? 1 YES 2 NO If yes, specific	ty Cuben, Mexican, Puerl NO Specify:	GIN7 (Specify Yes or No	4. RACE — American Indian, Black, White, etc.					
ETE	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)	of working 1	STATE DE	DT 4					
ed at once. BE COMPL	JACOB JACOBS	8. MOTHER'S NAME (Firs	t, Middle, Maiden Symame) HOFFNAN	N.					
De notific	190. INFORMANT'S NAME (Type/Print) DEDISE BAILEY 3509 E-LOM	BAND ST.	BALTO, M	D. 21224					
ner must	1 Buriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Campus) Company								
ai examiner	Thomas Akarde h. SKALDA F.H. BALTO., MD. ZIZLY								
event, the medical	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or haart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Approximate interval Between Onset and Death Due To (or as a consciouence or):								
r other traumatic event, the	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
lury, o	PART II. Other significant conditions contributing to death but not resulting in the underlying c	Ause given in Part i	24s. WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS					
shows any in: MEDICA			PERFORMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO					
A A	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 125. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)								
or item	EXAMINER? 1 YES 2 NO THER: 1 Input lent 2 ER/Outpet lent 3 DOA 4 Nursing Home 12 DATE OF IN HURY	A	her (Specify)						
marked, or BY PHY	1 Netural 5 Pending (Month, Day, Year) 266. Time OF NJURY AI WORK? 2 Accident Investigation Investigation Page 1 Accident Investigation Invest								
item 28 is PLETED	3 Suicide 6 Could not be 4 Homicide determined 28s. PLACE OF INJURY — At home, farm, atreet, factory, office building, etc. (Specify) 28s. CENTIFIER 28s. C								
	MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death								
TO BE COM	250. SIGNATURE AND TITLE OF CENTIFIER 250. SIGNATURE AND	D. 21242	29d. DATE S	SIGNED (Month, Day, Year)					
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30. NAME AND ADO

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hydiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event. The medical examiner must be marked.
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 2. DATE OF DEATH Juli 1995 550 H urang 4. SOCIAL SECURITY HUMBE 219-62-6704 7. DATE OF BRITH 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. IF UNDER 1 YEAR 30 1 K M 2 | F DAYS HOURS MIN MARYLAND 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH **EUTAW** 820 BALTIMORE DIRECTOR Ν. n/a RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION
BALTIMORE 10a. STATE 10b. COUNTY 10d. INSIDE CITY MARYLAND n/a 101. ZIP CODE 21202 1 XXYES 2 - NO 10e. STREET AND NUMBER FUNERAL UNITED STATES 820 **EUTAW** STREET 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerio Rican, etc.)

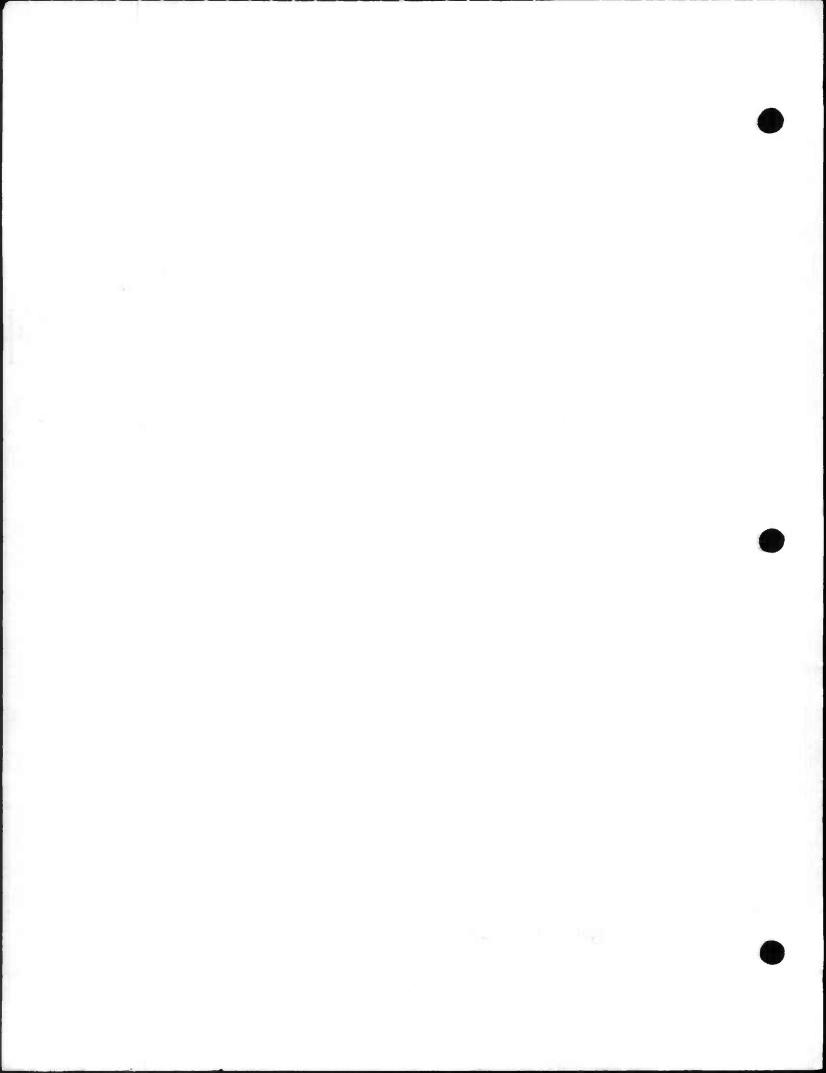
1 YES (X) NO Specify: 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, atc. 1 X Never Married 2 Married BY Specify: BLACK 3 Widowed 4 Divorced 18a. DECEDENT'S USUAL OCCUPATION

Work done during most of working COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work do life. Do NOT use retire Elementary/Secondary (0-12) IOT use retired.) LABORER College (1-4 or 5+) DELTA TIRE FACTORY 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Melden S MARY MORGAN PAUL FELDER BE 19a. INFORMANT'S NAME (Type/Print)
M/\(\text{O}\) \(\text{Y}\) \(\text{Y}\) \(\text{SO}\) \(\text{N}\) 196. MAILING ADDRESS (Strong and Number of Burel Poure, Number City of Burn State, Zip Code), MD 21211 2 20a METHOD OF DISPOSITION

1 Surie: 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State KING MEMORIAL 4 Donation 5 Other (Specify) **PARK** 7-8 RANDALLSTOWN, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 90 WM. C. MARCH FH.-1101 **AVENUE** E. NORTH mour 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. Lat only one cause on each line. Approximate interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition DUE TO (OR ASÍA CONSEQUENCE OF) minutes resulting in death) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST eyn. LAMOUNE Ve 1)15 EGS. VICE 4C PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY Intravauous Abure Drug 1 - YES 2 - NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN [X] PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL OTHER Inpetient 2 - ER/Outpetient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCUPED 1 Natural 5 Pending Investigation M BY 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide ETED 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my know COMPL riedge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. (Check only one) and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND THE OF CER BE 29c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 66 208900 2

CAUSE OF DEATH (ITEM 27) (Type, Print)

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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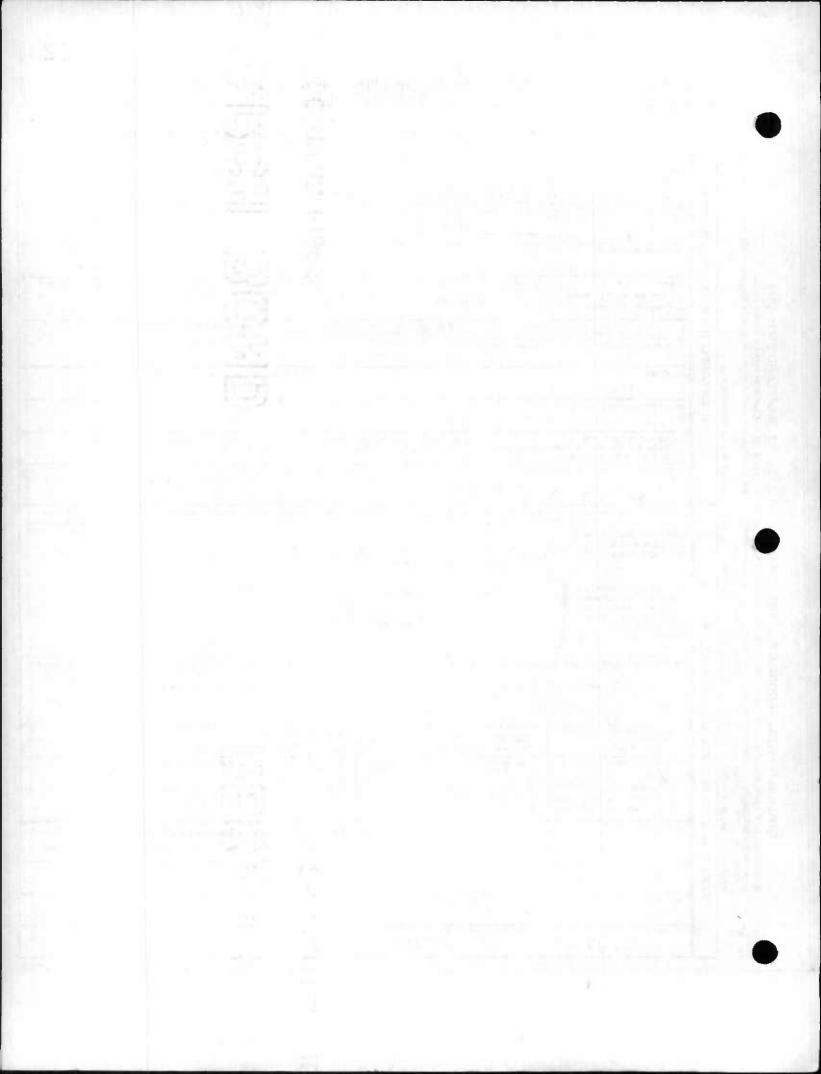
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Item10b, Film725, 7/7/95, 1t FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH **JUL** ELNORA 10:45am S. SEX 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR 7. DATE OF BIRTH B. SIRTHPLACE (State or Foreign IF UNDER 24 HRS. 1 2 1 F 84 YRS. Pennsylvania Se. FACILITY NAME (# 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH CARROLI DIRECTOR 6 e501 RESIDENCE OF DECEDENT Baltimore 10c. CITY, TOWN OR LOCATION 10e. STATE Mo Baltimore 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6524 Colgate Avenue 21222 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indien, Bleck, White, etc. If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Merried Specify: White IF YES. GIVE WAR OR DATES BY 3 X Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) 12 Homemaker Domestic 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) Oliver Wingert Dora Muth BE 190. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. Harry Byron Gifford (Son) 3400 York Way, Baltimore, MD 21222 20a. METHOD OF DISPOSITION
1 XBurlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Meadowrdige Mem. Park 7/8/95 Elkridge, MD 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HAIGHT FUNERAL HOME (P.O. Box 195) Yalak Sykesville, MD 21784 (410)-795-1400 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximata shock, or heart failure. List only one cause on each line. Interval Between **Onset and Death** IMMEDIATE CAUSE (Final disease or condition resulting in death) 4/zheimers 4415 DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **Item** EXAMINER? HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA rsing Home 6 - Residence 5 - Other (Specify) 6 27. MANNER OF DEATH 25e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28 is marked, 1 Naturel 5 Pending TO THE HOSPITAL DR ATTENDING PH TO THE FUNERAL DIRECTOR: After this be filed within 72 hours after death wi IMPORTANT: If Item 28 is marke 1 YES 2 NO BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, 1ectory, office building, stc. (Specify) 3 Sulcide 251. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicid 29a. CERTIFIER 1 Y CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMSER 29d, DATE SIONED (Month, Day, Year) BE J. M. MO 03288 7006 6

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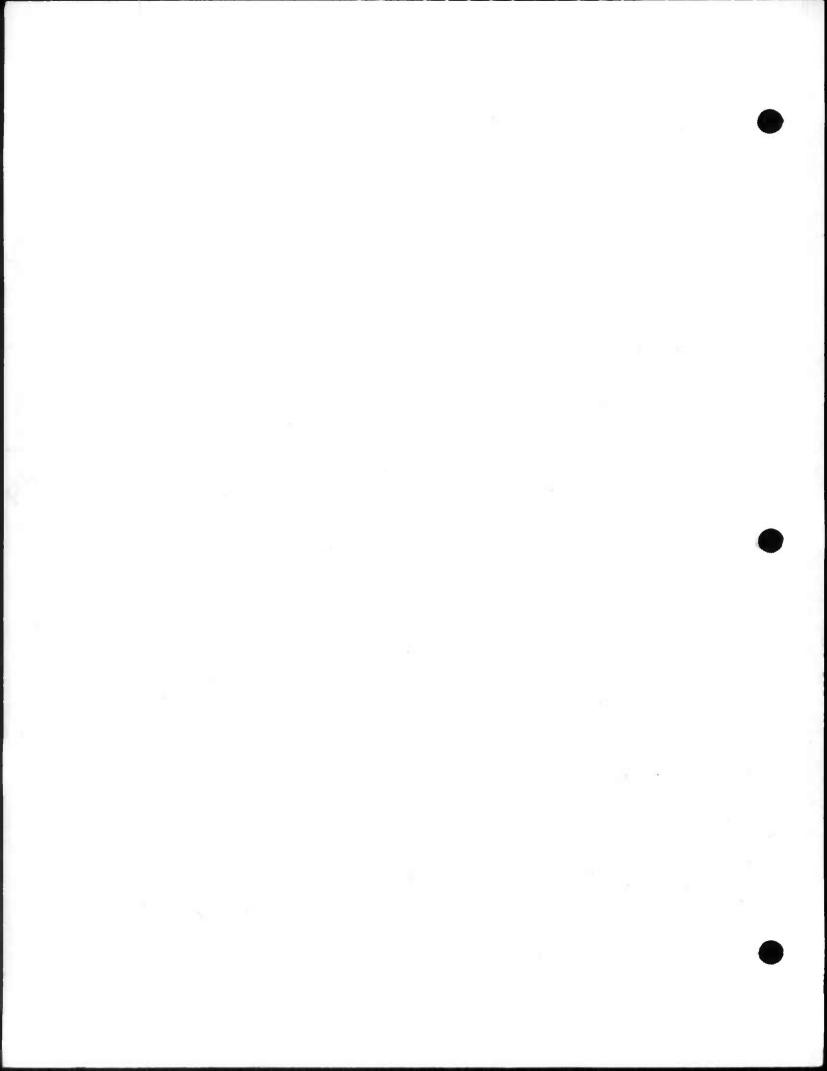
DIVISION OF VITAL RECORDS, P.O. BOX 68760

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		1 - FOR 1 - STATE REGISTRAR	STATE OF M				OF HEALTH AN	D MENT	AL HYGIEN REG. NO	E		
	0.00	1. DECEDENT'S NAME (First, Middle, Last) BENJAMIN FULLARD 4. SOCIAL SECURITY NUMBER 5. SEX CARGE (In yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS. YRS. WONTHS DAYS HOURS MIN.					MON		ž, 19	3. TIME OF DEATH		
								RS. 7. DAT	7. DATE OF BIRTH 8. BIRT		BIRTHPLACE (State or Foreign Country) S - C	
	œ	9e. FACILITY NAME (If not institution, give stre				9b. CITY, TO	OWN OR LOCATION O	F DEATH	DEATH 9c. COUNTY OF DEATH			
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	DIREC	100. STATE 10b. COUNTY	Alu		100-CIT	y, TOWN OR			10d. INSIDE CITY LIMITS? 1 A YES 2 NO			
SA CTREET AND MIGRAPHS							N OF WHAT COUNTRY?					
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at once	COMPL	TRATHER'S NAME (First, Middle, Lact)	Broll	SR,				A IN	, Middle, Maiden	Surneme)		
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event, the medical		23. PART Lenter the diseases, or co shock, or hear valure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death)	st only one ceu	t caused the de se on each line (OR AS A CONSE	toe	tic	/K	auch aa ce		ratory arrest	Approximate interval Between Onset and Death	
or other traumatic event,	TION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSE	QUENCE O	F):						
ther tra	RTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO	OR AS A CONSE	DUENCE O	F):						
, or	ш	resulting in death) LAST										
shows any injury,	EDICAL C	PART II. Other significent conditions	contributing to	death but not r	resulting	in the unde	riying ceuse given	in Part i.	24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
show	Σ	DID TOBACCO USE CONTRI	DI ITE TO CA	LICE OF DEA	TII V	C [] NO	T INCEPT	An M	1 1		YES 2 NO	
23	IAN	25. WAS CASE REFERRED TO MEDICAL	BUIE IO CA			H (Check only		AIN L				
or item	SICI		HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER: 4 Nursing	Home 5 Resider	ce 6 🗆 Oth	ner (Specify)			
Ked.	ву РНУ	27. MANNER OF DEATH Netural 5 Pending Investigation	28e. DATE OF (Month, Di		28b. TIM	URY	WORK?	28d. DE	ESCRIBE HOW II	NURY OCCUR	ED	
28 18	8	3 Suicide 8 Could not be determined	28e. PLACE O building,	F INJURY — At ho etc. (Specify)	me, farm,	street, factory,	office		CATION (Street e y or Town, State)	nd Number or i	Rural Route Number,	
흔	MPLET	29e. CERTIFIER 1 CERTIFYING PHYSICIA										
됩	BE CO	MATURE AND TITLE OF CERTIFIER	Of the Besie of ex	amination end/or	Investigation	n, in my opini	on, death occured at		te end place, en		suse(e) end menner ee stated. GNED (Month, Day, Year)	
MP	TOB	HAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	E OF DEATH (ITE	M 27) (Tvon	Print)	0.C.	М.Е		▶ JUI	LY 3,1995	
		JLARON LOCKE	- MD				eet. Ba	ltim	ore. M	arvla	and 21201	

Jabi Studen Robert

DHMH-16 Ray 1/89



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICATE OF	DEATH	REG	i. NO.	
	1. DECEDENT'S NAME (First, Middle, Last)	D. Gar	ham			2. DATE OF DEA	DAY	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER					May	2/ 17	75 6 /
	196-44-4810	5. SEX 6. AGE	E (In yrs. lest birthday) 43 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIR! (Month, Day, Y	bar)	BIRTHPLACE (State or Foreit Country)
	9a. FACILITY NAME (If not institution, give a		43 Ths.			MAY 14,		ENNSYLVANIA
Œ	LAUREL REGIONAL HOSPI				OR LOCATION OF DI AUREL	EATH		Y OF DEATH
DIRECTOR	RESIDENCE OF DECEDENT							
Æ	10a, STATE 10b. COUNT	Y	10c. CIT	Y, TOWN OR LOCA	TION			10d, INSIDE CITY
	MARYLAND PRI	NCE GEORGE		LA	UREL			LIMITS?
FUNERAL	100. STREET AND NUMBER 9101 CONTEE ROAD	APT. #102			r. ZIP CODE 0708		10g. CITIZE	EN OF WHAT COUNTRY? USA
BY FUN	11. MARITAL STATUS 1) Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 _ YES IF YES, GIVE WAR OR	S 2 X NO	If yes, sp	CENDENT OF HISPAI ecity Cuben, Mexica 2 XNO Specific	n, Puerto Rican, e	Ify Yes or No— 1.	4. RACE — American Indian, Black, White, etc. Specify: WHITE
0	15. DECEDENT'S EDU		16a. DECEDENT'S	USUAL OCCUPATION	ON	16b. KIND (OF BUSINESS/INDU:	STRY
Ä	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of a	work done during mo se retired.)	ost of working			
APL	12	Ø	ANIMAL	CARE TAKER	?	US C	OVERNMENT	
COMPLET	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, A	falden Surneme)	
BE (EDWARD J. GORHAM				GEORGENA	KEARNEY		
TO E	19e. tNFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street e	and Number or Rural	Route Number, City	or Town, State, Zip C	Code)
F	PATRICIA SHAFFER		RT #1,	Box 215,	EMLENTON,	PENNSYLVA	NIA 16373	
	20e, METHOD OF DISPOSITION 1 Buriel 2 XX Cremetion 3 Rem		Ob. PLACE AND DATE		ame of	DATE 2	Oc. LOCATION — CI	ty or Town, State
	4 Donation 5 Other (Specify)		BALTIMORE W	ASHINGTON	CREMATORY	5/22 L	AUREL, MAR	RYLAND
-	21. SIGNATURE OF FUNE BAL BERVICE LN	ENSEE /		22. NAME AI	ND ADDRESS OF FA	CILITY FLEC	K FUNERAL	HOME, INC.
	· (ala00	DI DOST	000	7601 3	SANDY SPRIM	NG ROAD, L	AUREL, MAR	RYLAND 20707
	23. PART I. Enter the diseases, or	complications that cause	ed the death. Do r	not enter the mo	da of dying, suc	h as cardlec or	respiratory stres	nt, Approximate
	shock, or heart fellure. IMMEDIATE CAUSE (Final)	List only one ceuse on	esch line				,	Interval Bets Onset and I
	disease or condition	An area	M wis	"H. Luca	11 out	D. cd.	- al.	Chisel and t
	resulting in desth)	a. DUE TO (OR AS	A CONSEQUENCE OF	FIX	Lenk	457	ophy	JWE
_		a. Progress DUE TO (OR AS DUE TO (OR AS	ed Tim	mund	Arren	in Sun	Dimo	5 was
임	Sequantisity list conditions, if sny, leeding to immediate	DUE TO (OR AS	A CONSEQUENCE OF	F):	-	7 - 1000	140110	0
8	csuse. Entar UNDERLYING	· ASOM	usitis	Anel	1 mon	10		13 Day
트	CAUSE (Disease or injury that initieted events	DUE TO (OR AS	A CONSEQUENCE OF	F).				
CERTIFICATION	reaulting in deeth) LAST	d						
	PART ii. Other algoliticant condition	s contributing to deeth	but not resulting	in the underlying	n ceuse given in	Part I 24a W	AS AN AUTOPSY	24b. WERE AUTOPSY FIND
MEDICAL					g cours given in	Pi	ERFORMED?	AMAILABLE PRIOR TO COMPLETION OF CAL
						— ¹º\	ES 2 NO	OF DEATH?
	DID TORACCO LISE CONT	DIDLITE TO CALICE	OF DEATH VE	c 🗆 No ja	LINICEDTAL		,	1 - YES 2 NO
AN	DID TOBACCO USE CONTI	KIBUTE TO CAUSE (26. PLACE OF DEAT		UNCERTAIL	<u>ч </u>		
SICIAN:	EXAMINER?	HOSPITAL:		OTHER:				
ا ¥	27. MANNER OF DEATH	1 Inpatient 2 ER/Ou 28e. DATE OF INJURY			e 5 Residence			
PHY	1 Natural 5 Pending	(Month, Day, Year)		URY WO	PRK?	28d. DESCHIBE	HOW INJURY OCCU	RED
B	2 Accident Investigation	28e. PLACE OF INJUR	IV — At home face		YES 2 NO	200 1 00071000	Change and the state of	0.10.1
	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Sp	ecify)	et, rectory, offic		City or Town,		Rural Route Number,
<u>u</u>	29e. CERTIFIER							
COMPLET	(Check only	CIAN: To the best of my kno						
8	2 MEDICAL EXAMINE		ion end/or investigatio	n, in my opinion, d	eeth occured at the	time, date end ple	ce, end due to the	ceuse(s) end manner es stat
BE	296. SIGNATURE AND TITLE OF CENTURE	oma	7, -		29c. LICENSE NUI	BER	29d. DATE S	SIGNED (Month, Day, Year)
2	MMCGI	-/////	Cham		D39	732	D 6	2/27/95
	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CALISE OF D	EATH (ITEM 27) (Type,	Print)	_	0. 1	1 1	A = = =
	1 mortes	1.17210	ain 34	Prince	· George	St. La	rure /	ID 20707
- 1	31. DATE FILED (Month Day Year)	32 REGISTRAR'S CO	NATURE		U			*

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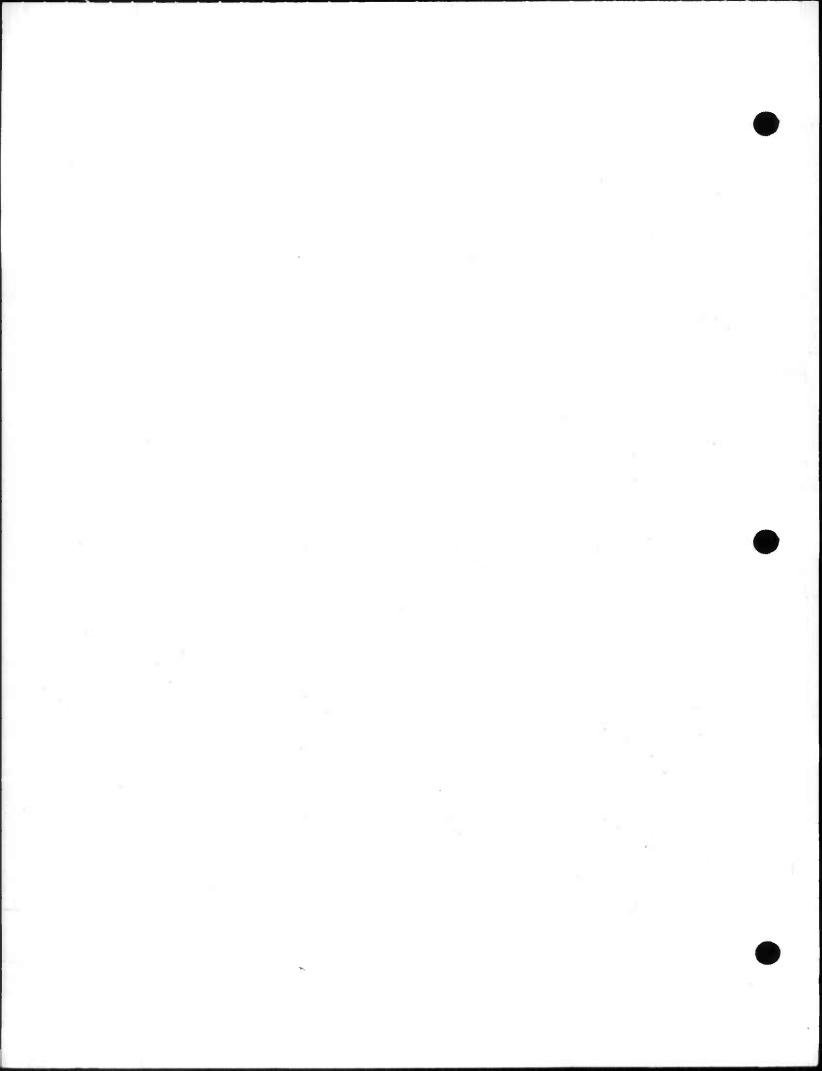
DIVISION OF VITAL RECORDS, P.O. BOX 68760

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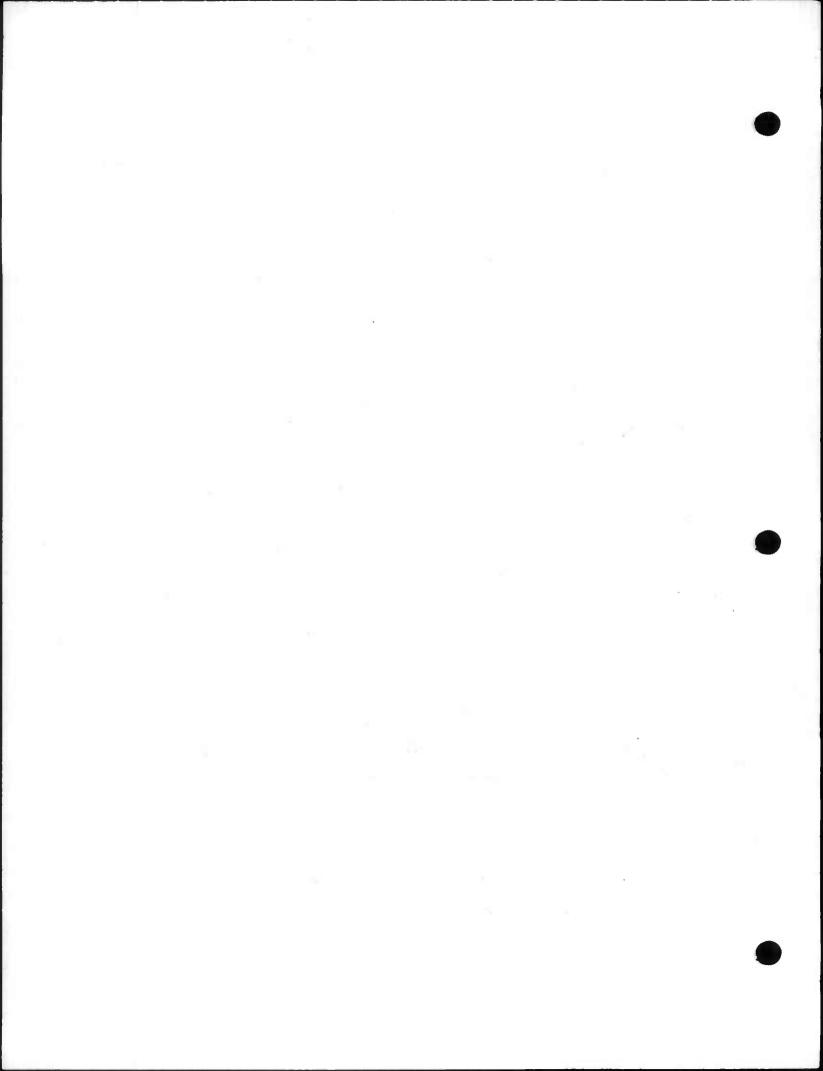
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ely filled in bration, or ren	thom out
executed with and complete burial, crem	HOAD ONE
ertificate be ing physician giene prior to	DOT TOUR
ires that the death certificate be executed within 10 hours after death. Page 6 may be retained by the hospital or attending physician signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transferant Hygiene prior to burial, cremation, or removal.	indu it of
requires that been signed to of Health a	SHOWS ONLY
CIAN: The law striffcate has the State Dept or Herm 23	20 11011 10
DING PHYSIC After this ce death with the	de menuncia
AL OR ATTEN AL DIRECTOR 2 hours after	04 11011
OTHE MOSFIAL OR ATTENDING PHYSICIAN). The law requires that the death certificate be executed withherest hours after death. Page 6 may be retained by the hospital or attending physician. OTHE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 feed within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, certaition, or removal.	I OHIUM

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH PURNELL С. GRAY SR. JUNE 1995 28 7: 13 p 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign Month, Day. 213-32-4588 DAYS HOURS 15,1937 1 N M 2 F 58 MARYLAND YRS. 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH THE **JOHNS** HOPKINS HOSPITAL DIRECTOR BALTIMORE CITY n/a RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 VES 2 NO MARYL AND n/a BALTIMORE FUNERAL 10a STREET AND MUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2805 Ε. CHASE STREET 21223 UNITED STATES 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No—
If yee, specify, Cuban, Maxican, Puerto Rican, atc.) 14. RACE — American Indien, Black, White, atc. 1 Never Married 2 Merried If yes, specify Cuban, BY Specify: 3 Widowed 4 Divorced Specify: BLACK COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe (Give kind of work done life. Do NOT use retired.) during most of working College (1-4 or 5+) **FABRICATOR** BETHLEHEM STEEL CORP. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname WILLIAM GRAY SR. WILLA MAE WILSON BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 DOROTHY M. GRAY 2805 ST., BALTIMORE, MARYLAND 21213 Ε. CHASE 20a, METHOD OF DISPOSITION
1 Description | Method | Disposition | Barnoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20ç. LOCATION — City or Town, State DATE ARBUTUS OT MEMORIAL 4 Donation 5 Other (Specify) PARK 7-3 ARBUTUS, MARYLAND 21. SIGNATURE OF PUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH **AVENUE** 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, shock, or heert feliure. Liet only one ceuse on each line. Approximate Interval Between IMMEDIATE CAUSE (Fine) Onset and Death disease or condition_ Myo car reculting in death) CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 TYES 2 NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES INO I UNCERTAIN I 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER:
4 | Nursing Nome 5 | Residence 8 | Other (Specify) 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 28a. DATE OF INJURY (Month, Day, Year) 27. MANYER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 1 YES 2 NO BY Investigation 2 Accident 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28e. PLACE OF INJURY — At home, ferm, street, factory, office 3 Suicide COMPLETED 6 Could not be 4 Nomicide 29a, CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner ea stated. 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER. 29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day,



		1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF H		MENTAL HYGIENI REG. NO.	Ε		
		1. RECEDENT'S NAME (First, Middle, Last)	A G	EDRA	JR		2. DATE OF DEATH	1993	3. TIME OF DEATH A	
P		4. SOCIAL SECURITY NUMBER 214-24-9669	1 X M 2 🗆 F 6	7 yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Morth, Day, Year) NOV . 21, 192	27 Mai	ryland	
1, 2, 3 should	стоя	90. FACILITY NAME (If not institution, give s Fallston General RESIDENCE OF DECEDENT				Ston	EATH	9c. COUNTY OF D		
permit, Pages 1	DIRE	10e. STATE 10b. COUNT	ford	10c. CIT	Y, TOWN OR LOCAT	el Air			10d, INSIDE CITY LIMITS? 1 🔀 YES 2 🗌 NO	
5	FUNERAL	1405 Marywoo	d Drive		101	ZIP CODE 210	14	10g. CITIZEN OF V	S.A.	
215-0020 attending physicien. se as the burial-transit	BY	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 (X) YES IF YES, GIVE WAR OR DA Korean Con	2 NO ATES	If yes, spi	ENDENT OF HISPAN ecity Cubers, Mexica 2 X NO Specify	NIC ORIGIN? (Specify Yes n, Puerto Ricen, etc.)	Blac	E — American Indian, k, White, etc.	
27 for u	LETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION	16a. DECEDENT'S	USUAL OCCUPATION Work done during mose retired.)	ON st of working	16b. KIND OF BUS			
LAND 2 the hospital of detached for	COMPL	17. FATHER'S NAME (First, Middle, Last)	Codmo Co	Claims	Manager		ME (First, Middle, Maiden S		pany	
MARYL retained by 5 should be		Charles Albert 190. INFORMANT'S NAME (Typos/Print) Muriel W. Gedra	(wife)				Poute Number, City or Town Bel Air,	n, State, Zip Code)	4	
ME, may be compared to page		20e. METHOD OF DISPOSITION 1	206.	PLACE AND DATE	of Disposition (Na ther place) int Crema	me of	DAT: 20c. LOC	CATION — City or To		
Pune eath	SAL CERTIFICATION	21. SIGNATURE OF FUNERAL SERVICE LIC			Schim	unek Fun		, Inc.	21236	
withtenest hours holes holes holes to recommend on the mediant.		23. PART I. Enter the disbeases, or cahock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	a. Such	the death. Do nach lina.	Cau	de of dying, such	h as cardiac or reapir	atory arreat,	Approximata interval Batween Onset and Death Minutes	
th certificate be executed by significate be executed by signification and I hygiene prior to burnatify		Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	· HTA	CONSEQUENCE OF	Hrs De	eten - Co	bin UHDL		35 yrs	
requires that the deal een signed by the ath of Health and Menta shows any Injury.		PART II. Other significent condition	e contributing to desth be	o by	In the underlying	ceuse given in	Part I. 24s. WAS AN A PERFORM	NUTOPSY 24b	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 2 10	
V: The law requires that cate has been signed I State Dept. of Health a Item 23 shows any	Ä	DID TOBACCO USE CONTI		F DEATH YE	S NO (Check only one)	UNCERTAIN	1 🗆			
certification the	PHYSIC	1 Tes 2 NO 27. MANNER OF DEATH	HOSPITAL: 1 Inpatient 2 ER/Output 28a. DATE OF INJURY (Month, Day, Year)	28b. TIM		JRY AT	8 Other (Specify) 28d. DESCRIBE HOW IN	JURY OCCURED		
L OR ATTENDING PHYS. L DIRECTOR: After this hours after death with	ED BY	1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be determined	28a. PLACE OF INJURY building, atc. (Speci	At home, ferm,	M 1 V		28t. LOCATION (Street or City or Town, State)	nd Number or Rural I	Route Number,	
A 35 =	COMPLET		CIAN: To the best of my knowle						I) and manner as stated	
TO THE HOSPI TO THE FUNER be filed within	BE	296. SIGNATURE AND TITLE OF CERTIFIER	ER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. R WD, MPH 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)							
5+1	10	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA		Print) 10	4 Plu	moree la	2d. B.	el Air	
_ '		31. DATE FILED (MOST) AND SOTO	A REGISTRARY BIGH	ATURE						



DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 7.45 7 Tully 04 5. SE) E OF Billion Hours 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. Month, 1 M 2 🗆 F 2938 DAYS HOURS MIN. ١a Pages 1, 2, 3 should OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR umore DECEDENT STATE 10b. COUN 10d. INSIDE CITY Sa 10 1 YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? S 144 2 Cirlupa een signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit of Health and Mental Hygiene prior to burial, cremation, or removal. 229 retained by the hospital or attending physician. 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuben, Mexican, Puerto Rican, atc.) 12. WAS DECEDENT EVER IN U.S., ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE - American Indien, Black, White, etc. 1 Never Merried 2 Merried If yes, specify Cube Specify: Black BY Specify: 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) College (1-4 or 5+) countino Pechnician (Accounting once. NAME (First, Middle, Last) 16. MQTHER'S NAME (First, Middle, Maiden Surname Shaw ward notified at BE 'S NAME (Type/Print 19b. MAILING ADDRESS (Street and Number or Rural Route Number 2 Edward wer 21229 2 51 15a Ito, md Gasque Page 6 may be 9 20a METHOD OF DISPOSITION

1 Buriel 2 Cremation 3 Removal from State PLACE AND DATE OF DISPOSITION (Name of Foc. LOCATION -City or Town, State must emeter Co, md metery demetory or other (4Ce) Donation 6 Other (Specify) the medical examiner 21. SIGNATURE-OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY arch F. H-West hours after death. 300 Wabash 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart feliure. List only one ceuse on each line. interval Between IMMEDIATE CAUSE (Fine) Onset and Death that the death certificate be executed within 24 disease or condition in neu monia Preumoly stis 6 monte resulting in death) event. DUE TO (OR AS A CONSEDUENCE OF) Yeary ALDS traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEDUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING 1/200 Anemin CAUSE (Disease or injury or other DUE TO (OR AS A CONSEDUENCE OF): that initiated events reaulting in death) LAST Unknown injury. PART ii. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Denydration Hypoglycemia failure, shows any 1 TES 2 NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires Thrush in oral Cavim 1 TYES 2 NO peen DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: has be Dept. YES □ NO □ UNCERTAIN ☑ 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h the State EXAMINER? HOSPITAL: 1 TES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | 4 Nursing Nome 5 Residence 6 Other (Specify) 10 27. MANNER OF DEATH 28b. TIME OF 28e. DATE OF th JURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED marked. 1 Natural 1 YES 2 NO BY After 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) DIRECTOR: Af hours after de tem 28 is r 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide TO THE HOSPITAL OR ATTE TO THE FUNERAL DIRECTO be filed within 72 hours af IMPORTANT: It Item 21 29e. CERTIFIER 1 December 2018 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner se stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(a) end manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d, DATE SIGNED (Month, Day, Year) weyn 24389 TIMA 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) ZAIGI WANG MEMORIAL union HOSPITAL BALTIMORE MD 21218 A A 32 HE SISTEMAN'S AVAILABLE

AND IN

Pages 1, 2, 3 should

permit.

TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit is
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: if Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

2

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

1006 Taylor Ave

M.D

Khin M. Tun,

95 20518 FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG NO 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH Anna Gawrys July 5,1995 4:05 P 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5 SEY IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign July 23,1902 213-30-7313 1 🗌 M 2 👽 F 92 Maryland 9e. FACILITY NAME (If not institution, give street and number 96. CITY TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH DIRECTOR Meridian Multi Medical Center Towson Baltimore RESIDENCE OF DECEDENT 10c CITY TOWN OR LOCATION 10d. INSIDE CITY **Maryland** Baltimore Parkville 1 TES 2 X NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1712 Glen Keith Blvd. 21234 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yea, specify Cuben, Mexican, Puerto Rican, atc.)

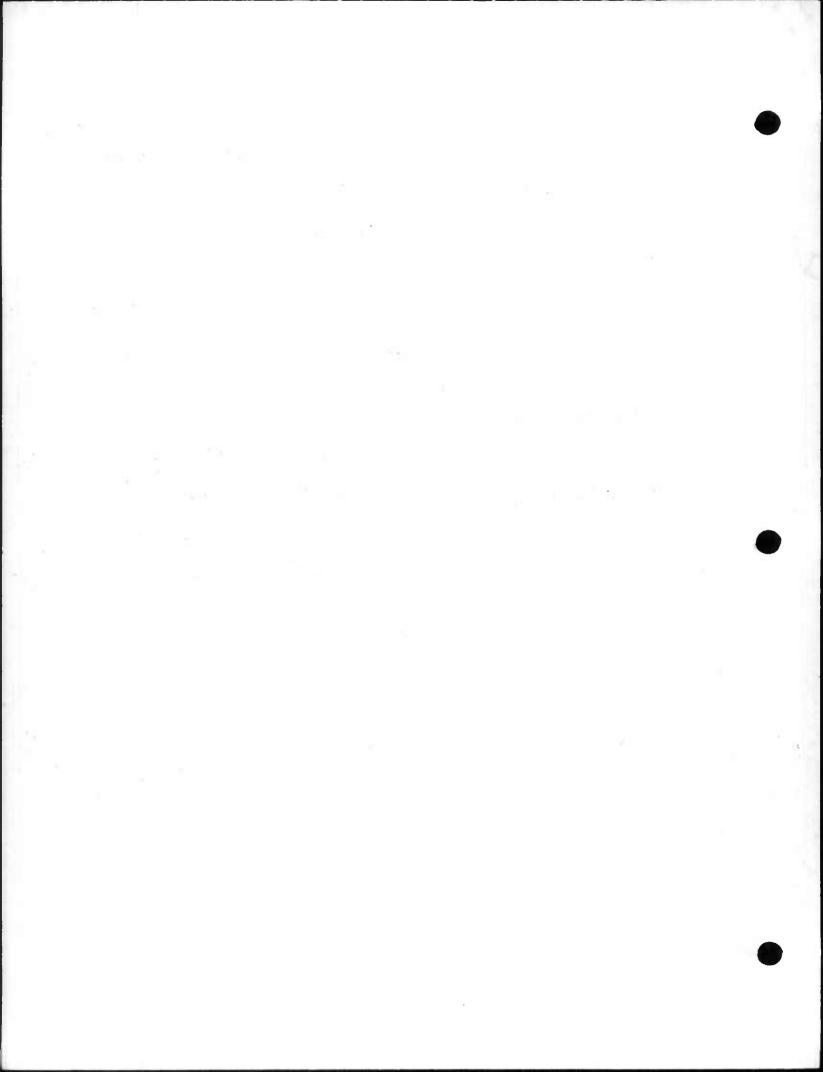
1 YES 2 NO Specify: 14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Merried BY 3 Widowed 4 Divorced Specify: White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 165 KIND OF BUSINESS/INDUSTRY 8 yr's College (1-4 or 5+) Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle Maiden Sumame) notified at Francis Joseph Drenga BE Marvanna Piskor 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Irene L. Gegorek 1106 Pelham Wood Rd. 21234 Baltimore, Md. must be 20e. METHOD OF DISPOSITION

1 X Buriel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE St. Stanislaus Cem. 4 Donation 5 Other (Specify) 7/8/95 Baltimore.Md examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES Baltimore, Md. 21214 Haul Leonard J. Ruck, Inc. 5305 Harford Rd. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or reapiratory arrest, shock, or heart failure. List oph one ceuse on each line. Approximate interval Between IMMEDIATE CAUSE (Fine) Onaat epid, Desth the disease or condition_ elmiratory In reaulting in death) or other traumatic event, DUE TO OR AS A CONSEQUENCE OF) Heard ongetive PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING .0 . CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST item 23 shows any injury, PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO INCERTAIN I 25. WAS CASE REFERRED TO MEDICAL 25. PLACE OF DEATH (Check only one EXAMINER? OTHER:
4 Nursing Home 5 - Residence 8 - Other (Specify) HOSPITAL: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a, DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY Investigation Accident 28e. PLACE OF INJURY — At home, term, atreet, tectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 8 Could not be COMPLETED 4 Homleide 29s. CERTIFIER 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end placa, end due to the cause(e) end menner es stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(e) end menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

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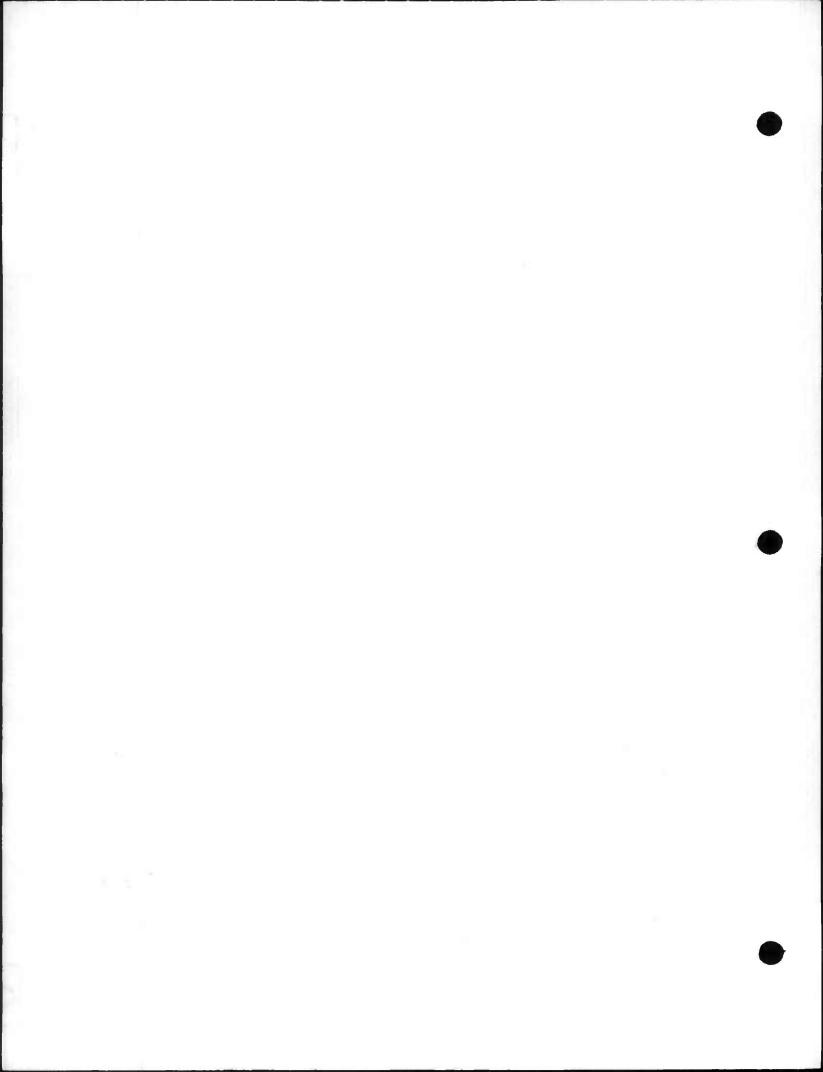
attending physician death certificate be

use as the burial-transit permit. Pages 1, 2, 3 should

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	N: The law requires that the death certificate
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH_ 703 AM YEAR SAM GRANT June 995 30 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) APRIL 24, 5 SEY 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 1 X M 2 - F 579-07-1368 86 1909 SOUTH CAROLINA Se. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH STELLA MARIS HOSPICE DIRECTOR BALTIMORE CITY N/A RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND N/A BALTIMORE CITY 1X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3819 GARRISON BLVD. 21215 USA. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ∑NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Married If yee, specify Cuban, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: BY Specify 3 Widowed 4 Divorced BLACK COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig Elementary/Secondary (0-12) College (1-4 or 5+) TRUCKER UNKNOWN SELF-EMPLOYED 17. FATHER'S NAME (First, Middle Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ ROBERT GRANT PEARL TINDALE BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 AZALEE GRANT 3819 GARRISON BLVD., BALTIMORE, MARYLAND 21215 9 20a. METHOD OF DISPOSITION
1 M Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must MT: AUBURN CEMETERY 4 Donation 5 Other (Specify) 7-8-95 BALTIMORE, MARYLAND JOSEPH H. BROWN JR. FUNERAL HOME, examiner FUNERAL SERVICE, LICENSEE 1913 W. BALTIMORE ST., BALTIMORE, MD.21223 completely filled in by the rial, cremation, or removal. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, the medical Approximate shock, or heart feilure. List only one cause on each line Interval Between prior to burial, cremation, or MEDIATE CAUSE (Final Onset and Death disease or condition PROSTATE CANCER event, DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions. OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other Mental Hyglene OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 Injury, signed by the a Health and Ment PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? PERFORMED? shows any 1 - YES 2 NO 1 | YES 2 | NO 6 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Tem Tem State HOSPITAL: 1 TES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 | Nursing Home 5 | Residence 8 M Other (Specify) HOSPICE 6 the 27. MANNER OF DEATH 28e. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED marked, with 1 Natural
2 Accident 5 Pending 1 YES 2 NO DIRECTOR: After the hours after death v BY Investigation 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28 18 1 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide determined TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTL DE filed within 72 hours at IMPORTANT: If Item 2: 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. (Check only one) 2 MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occurred at the time, data and placa, end due to the ceuse(a) and mennar as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE 2 195 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2300 DULANEY VALLEY ROAD TOWSON, MD 21204 KENDALI. FAULKNER. 32. BEGISTRAR'S SIGNATURE



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Nem 28 is marked, or Nem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In	yrs. lest b		IF UNDER 1		IF UNDE	R 24 HRS.	7. D.	ATE OF BIRTH	1 1 2		IPLACE (State or Foreign
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~	90. FACILITY NAME (If not ins	ititution, give si	treet and number)				9b. CITY,	TOWN (DR LOCAT	ION OF DI	EATH		9c. CO	UNTY OF D	PEATH
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ဗ	17. FATHER'S NAME (First, Mic	ddle, Last)										rst, Middle, Maiden			
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10	19a. INFORMANT'S NAME (Ty											Vumber, City or Town			
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	20a. METHOD OF DISPOSITION 1. Burlal 2 □ Cremation	DN 1 3 □ Remo	oval from State				F DISPOSIT							Arb	
	4 Donation 5 Other	Specify)		M	DUL	UA	CEMET	ERY			7-8	8-95 BAL	TIME	RE,	MD.
	21. SIGNAPUNE OF FUNERAL	SERVICE LIC	PISEE			-				DD A		JR. FUN	ED AT	ном	F D A
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CERTIFICATION	Sequentially list condition is away in death) Sequentially list condition is any, leading to immedicause. Enter UNDERLY if CAUSE (Disease or injurity in the initiated events resulting in death) LAST	ona, liate	DUE TO	(OR AS A C	CONSEQUE	NCE OF):	of	- (LB.	re	ls			Interval Batween Onset and Daath
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PHYSICIAN: MEDICAL	PART II. Other algorifican						the und				_	YES 2	MED?	24b	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 \(\sqrt{N} \) NO
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B	2 Accident Ir	vestigation	28a. PLACE O	F IN HIRY	At home	00~	> "		//	NO	-	9,00	~ ~	2/0	V
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2	30 MAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF DEAT	TH (ITEM 2					.C.M		•			03 1995
	31. DATE FILED (Month, Day, M	7 1995	32. PAGISTRA	TS SIGNAT	111		nn S	str	eet	<u>Ba</u>	lt	imore.	Ma	ryla	nd 21201
	JUL 0	7 1995	- fellad	aveleo	X-MAN	all									



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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		1. DECEDENT'S NAME (First	t, Middle, Last)								2. DATE OF	DEATH			3. TIME OF DEA	ATH
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		4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (In	yrs. last birthday)	IF UNDER	R 1 YEAR	IF UNDER	R 24 HRS.	7. DATE OF E	HTRE		8. BIRTH	PLACE (State or I	Foreign
		217 76 9668	3	1 M 2 D F	35	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Da			Country	V)	•
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		17. FATHER'S NAME (First, M							1000		ME (First, Middle					
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	2	19s, INFORMANT'S NAME (Route Number, C				764	
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180	ı	20a. METHOD OF DISPOSIT 1 ☐ Burial 2 🎇 Crematic		oval from State		LACE AND DATE			me of		DATE			City or Tox		
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		23. PART I. Enter the d	iseeses, or	complications the	caused b	death. Do r	ot anter	tha mo	de of dy	ing, such	h as cardiec	or respire	atory an	rest,	MD 214 Approxim	
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3	3	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:	28.	PLACE OF DEAT	OTHER									
5 2	2	1 YES 2 NO		1 Inpatient 2			4 🗆 Nun	sing Home		eldence	8 Other (Spe	ecify)				
6 1	- 10	27. MANNER OF DEATH	Pending	28a. DATE OF (Month, Di	ey, Year)	28b. TIM	URY	28c. INJI	RK?	,	28d. DESCRIE		4	CURED	,	
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COMBI ET		29a. CERTIFIER				str					-/-	/		. A. C	o, Hd	
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	ξ 	2 X MEDI	ICAL EXAMINE	R: On the basis of a	amination ar	nd/or investigatio	n, la my o	pinlon, de	with occur	ed at the t	time, deta and	place, and	dua to th	e cause(a)	and manner as	stated.
L L	u II	296. SIGNATURE AND TITLE	OF CERTIFIES	- 1	911				29c. LICE	ENSE NUM	IBER		29d. DATI	E SIGNED	(Month, Day, Year)	
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WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

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JULY 5, 1995

1995

9c. COUNTY OF DEATH

Interval Between Onset and Dasth 10 days

2. DATE OF DEATH MONTH

2. DATE OF BIRTH (Month, Day, Year) AUG. 30, 1909

JULY

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1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

218-07-0753

JAMES

Se. FACILITY NAME (If not institution, give street and number,

CHURCH HOME

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permit, Pages 1,	DIRE	MARYLAND 106, COUNTY	n/a		10c. CITY, TO	WN OR LOCAT	LTIMORE				10d. X	INSIDE CITY VIMITS? VES 2 \(\begin{array}{c} \text{NO} \\ \text{NO} \
TS.	FUNERAL	100. STREET AND NUMBER 2137 E. CH	IASE STREE	T		101	2121	3		UNI		STATES
5-0020 anding physician.	B	11. MARITAL STATUS 1 Never Married 2 Married 3 XXWidowed 4 Divorced	12. WAS DECEDENT EV FORCES? 1 1 1 IF YES, GIVE WAR C	YES 2 X	MED (C)	If yes, sp	ENDENT OF HISPAI ecity Cuben, Mexica 2 X X Specif	in, Puerto Rica	pecify Yes on, etc.)	r No- 14.	RACE — A Black, Wh Specify: B	
pital or atte	COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(Gi	CEDENT'S USU. I've kind of work of Do NOT use net _ABORER	done during mo red.)	DN ist of working			HEM S		CORP.
2 8 E	BE CO	17. FATHER'S NAME (First, Middle, Last) JAMES HILL					16. MOTHER'S NA HARI	RIET				
ay be retained by page 5 should b	5	19a. INFORMANT'S NAME (Type/Print) HAZEL HILL		191	L112	WICKL(DW ROAL	Poute Number, 0	City or Town, FIMOR	State, Zip Coo	RYLAN	D 21229
mestor,		20e. METHOD OF DISPOSITION 1 XX Quital 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)		20b. PLACE A	NUEL BA	SPOSITION (NO	CHURCH	7-12		ITHF IE		Stata VIRGINIA
death.		21. SIGNATURE OF FUNERAL SERVICE LIC	Magn	<u> </u>			D ADORESS OF FA		L01 E	. NORT	H AV	E,BALTO.
th certificate be executed within za ending physician and completely filling bygiene prior to bunal, cremation, or other traumatic event, the	CERTIFICATION	23. PART I. Enter the diseases, or cahock, or heert failure. I IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated evants resulting in death) LAST	h ss cardiac	s cardiac or reapiratory srrest, In On								
requires that the deen signed by the t. of Health and Meshows any injury	MEDICAL	PART II. Other significant conditions DID TOBACCO USE CONTR						1	. WAS AN AL PERFORMI YES 2	E0?	COM OF D	E AUTOPSY FINDINGS LABLE PRIOR TO PLETION OF CAUSE JEATH? YES 2 NO
SICIAN: The law certificate has the State Dept or Item 23	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	26. PLAC	E OF DEATH (C	heck only one) HER:	e 5 🗆 Rasidence		ac(fy)			
the with the	ву рну	27. MANNER OF DEATH 1	28a. DATE OF INJU (Month, Day, Ye	ear)	28b. TIME OF INJURY	28c. tNJ WO M 1 1	URY AT RK? 'ES 2 NO	28d. DESCRI		URY OCCUR	EO	-
ATTENDI RECTOR: A Irs after di m 28 is	ETED	3 Suicide 6 Could not be determined	28e. PLACE OF INJ building, atc. (IURY — At hor (Specify)	ne, farm, street,	, fectory, office		261. LOCATIO City or To	N (Street and wn, State)	Number or R	tural Route I	Vumber,
TO THE HOSPITAL OR ATTENDING ITO THE FUNERAL DIRECTOR: After be filed within 72 hours after death IMPORTANT: If Item 28 is man	COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC MEDICAL EXAMINER	CIAN: To the best of my k								use(s) and	menner as stated.
TO THE HOSPI TO THE FUNER De filed within IMPORTANT:	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER	*				29c. LICENSE NUN D 48396		2	DATE SH		in, Day, Year) 1995
~	-	30. NAME AND ADDRESS OF PERSON WHO CLARENCE SARKO	COMPLETED CAUSE OF	DEATH (ITEN	1 27) (Type, Print,	CHURC	H HOSP	THE				

Jaly STAREGISTRAR'S SENATURE

31. DATE FILED (Month, Day, Year) JUL 07 1995 W.

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5. SEX

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

MONTHS

IF UNDER 1 YEAR IF UNDER 24 HRS.

BALTIMORE

HOURS

9b. CITY, TOWN OR LOCATION OF DEATH

RAL TIMORE

MIN.

DAYS

HILL

YRS.

6. AGE (In yrs. lest birthday)

85

HOSPITAL

95 20522

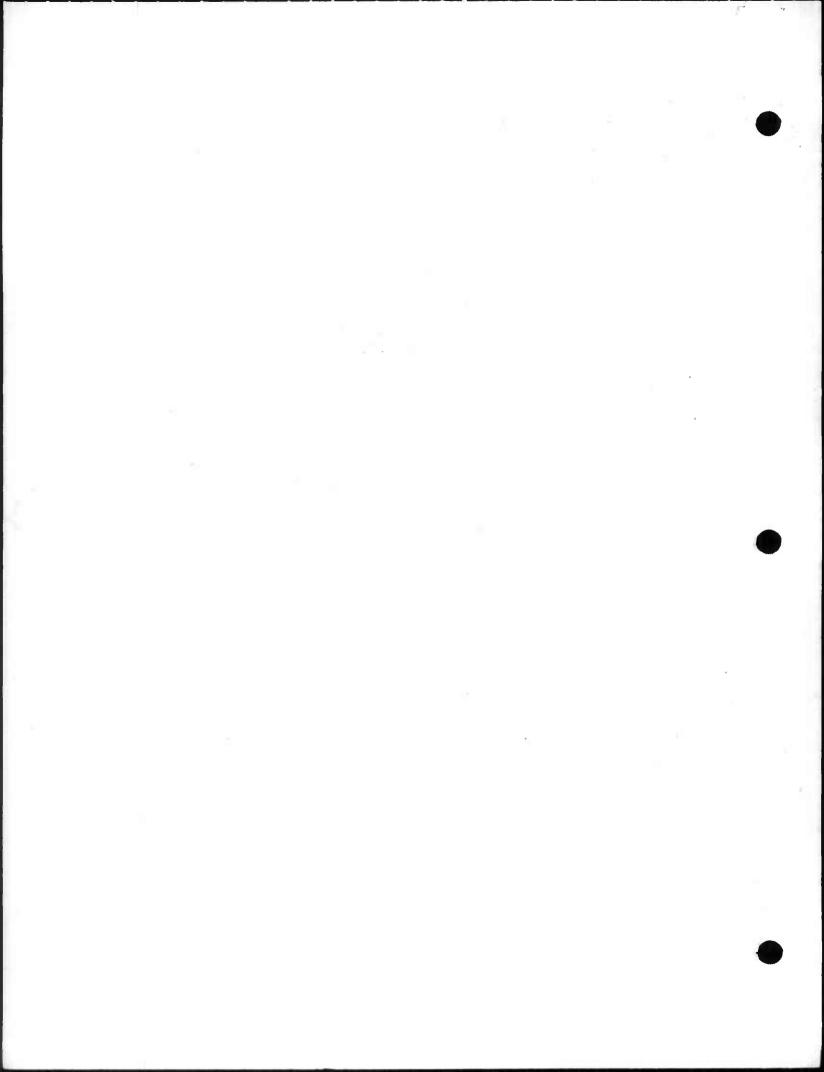
11:35 P M

6. BIRTHPLACE (State or Foreign

n/a

VIRGINIA

DHMH-16 Rev 1/89



Pages 1, 2, 3 should

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit perm	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
2	2	8	Σ

Items#1.2.8.G-film 725 per F.H 7/7/95 P.C FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH 3. TIME OF DEATN Shanterry Denise Hope YEAR 2:44 PH 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH RIRTNPLACE (State or Foreig IF UNDER 24 HRS. OCT.11,1964 Baltimore, MD 219 86-9431 HOURS 1 M 2 X K 30 YRS 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN UNIVERSITY HOSPITAL DIRECTOR BALTIMORE CITY n/a RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY
LIMITS?
1 VES 2 NO MARYLAND n/a BALTIMORE 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 728 REEDBIRD **AVENUE APT 301** 21225 UNITED STATES 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 TINO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 TES 2 NO BY Specify: Specify: 3 Widowed 4 Divorced **BLACK** 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION ecify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Spe (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) CASHIER 12th 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) ROBERT L. RICKS SR. CATHERINE HOPE BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 HELEN RICKS 528 PULASKI STREET, BALTIMORE, MD 21223 20e METHOD OF DISPOSITION
1 Deutel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State MEMORIAL 4 Donation 5 Other (Specify) PARK DUNDALK, MARYLAND 21 SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH **AVENUE** /eun 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heert fellure. List only one cause on each line interval Batwaen IMMEDIATE CAUSE (Final **Onset and Death** disease or condition Hepatie Failure DUE TO (OR AS A CONSEQUENCE OF) resulting in death) Patitis CERTIFICATION Sequentially list conditions, if any, leading to immediate TO (OR AS A CONSEQUENCE OF) cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART ii. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert i. PHYSICIAN: MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO OF DEATN? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL:
1 Pinpetient 2 ER/Outpetient 3 DOA OTHER:
4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28e, DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 26d. DESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO ВУ Investigation 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide determined 29e. CERTIFIER 1 CERTIFYING PNYSICIAN: To the beet of my knowledge, deeth occurred at the time, date and place, and due to the cause(e) and manner on stated. (Check only one) 2 ___ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 29b, SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 7/3 15 2

32 REGISTRAR'S SIGNATURE

UNIVERSITY

HOSPITAL, BALTIMORE, MARYLAND

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M. CUNNINGHAM,

ROCHELLE

31. DATE FILED (Month, Day, Year)

JUL 0 7 1995

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
SICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 shoult the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. To item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

DIRECTOR

FUNERAL

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CERTIFICATION

MEDICAL

PHYSICIAN:

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27. MANNER OF DEATH

1 Natural

2 Accident

3 Suicide

4 Homicide

95 20524 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH HARRELL **EVELYN** RUTH Jul 3 1995 7:59 pm 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign June 27, 213-05-0496 77 1 - M 2XXF Maryland YRS. 1918 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Saint Joseph Medical Center Towson, Maryland Baltimore RESIDENCE OF DECEDENT 10q. STATE 10c. CITY, TOWH OR LOCATION 10b. COUNTY 10d. INSIDE CITY Maryland Baltimore Chase 1 YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRYS 14 Mango Trail 21220 U.S.A. 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIYE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married
3 Divorced Specify White 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple (Give kind of work done life, Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Receiving Department Sears Department Store 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Fleda Benjamin Benjamin Harris 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Malcolm Harrell 14 Mango Trail, Chase, Maryland 20s. METHOD OF DISPOSITION

W Burisl 2 Ommation 3 Removal from State
4 Donation 9 Pether (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State ery, cremetory or other place) WoodLawn Cemetery 7/6 Woodlawn, Maryland 21. SIGNATURE OF SONERAL SERVICE LICE 22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 21211 3631 Falls Road, Baltimore, Maryland 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shades, or heart failure. List only one ceuse on each line. **Approximata** interval Between Onset and Death **IMMEDIATE CAUSE (Final** disease or condition_ CARDIAC ARREST SECONDARY TO ARRYTHMIA recuiting in death) DUE TO (OR AS A CONSEQUENCE OF): RESPIRATORY FAILURE HOURS Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury ACUTE IDIOPATHIC PANCREATITIS DAYS DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the undarlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY 1 YES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN

25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2 NO 26. PLACE OF DEATH (Check only one)

HOSPITAL: OTHER: 1 | Inpatient 2 | ER/Outpetient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify)

28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? м 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28d. OEŞCRIBE HOW INJURY OCCURED 1 YES 2 NO 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(a) and manner as stated.

SIGNATURE AL	ND TITLE OF C	ERTIFIER		1110
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1/10/2	and L	VI IV	Hrich	
1 1100	101-		C 11 1-000	
NAME AND ADD	DESC OF DED	CONTRACTOR	WETER CALLED	

D31826

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year)

PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Saint Joseph Medical Center Towson, MD RICHARD L. LINTHICUM, M.D.

31. DATE FILED (Month, Day, Year)

296 SIGNATURE AND TITLE OF CERTIFIER

5 Pending Investigation

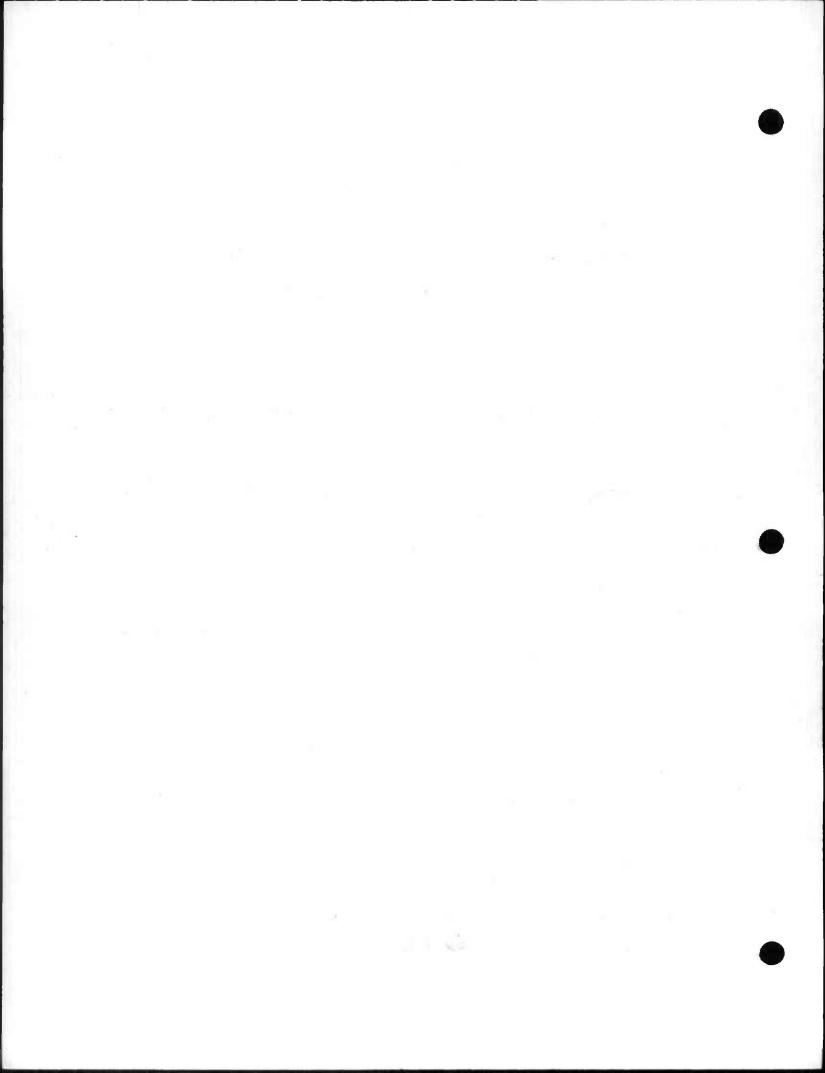
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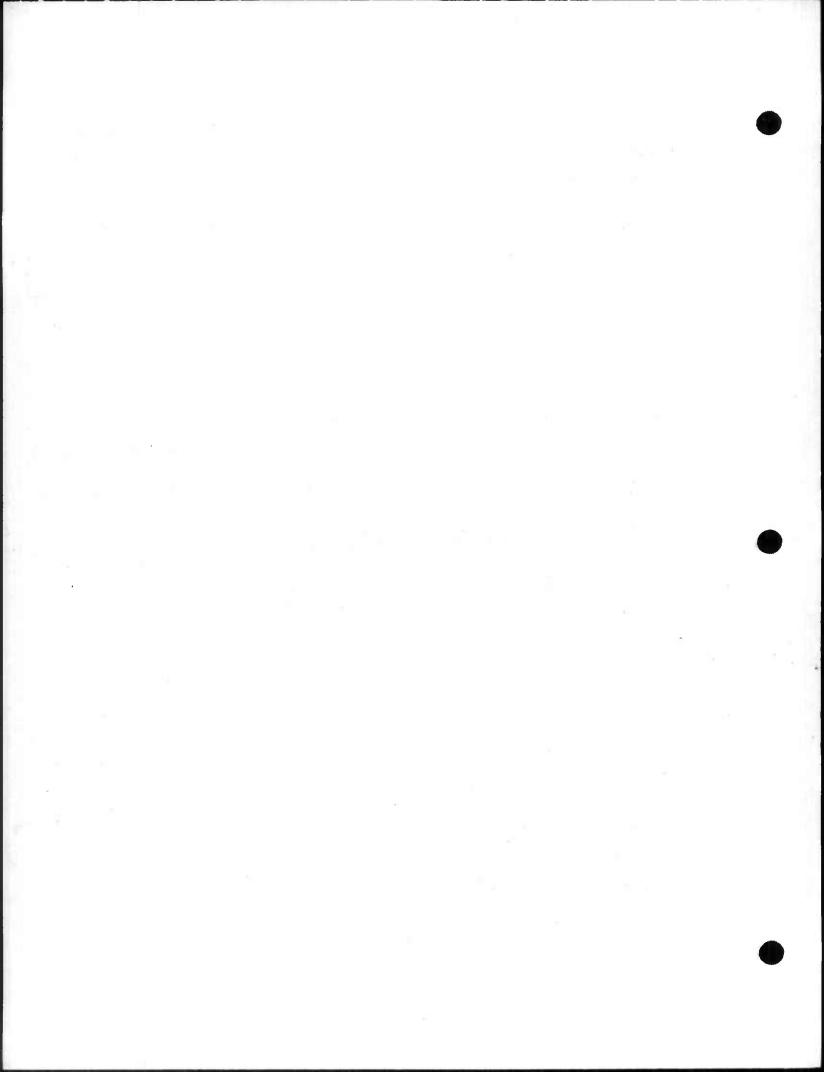
		1 - STATE OF STATE OF	MARYLAND / DE CERT	PARTMENT OF		MENTAL HYGIEN REG. NO.	E					
		1. DECEDENT'S NAME (First, Middle, Last) Alice	c. Herso	hberger		2. DATE OF DEATH DA July 6,	Y YEAR	3. TIME OF DEATH 9:15 AM M				
B		4. SOCIAL SECURITY NUMBER 219-30-9616 1 □ M 2 ☒ F	6. AGE (in yrs. last birth	day) IF UNDER 1 YEARS. MONTHS DAY		7. DATE OF BIRTH (Month, Day, Year) Jan 27,		LACE (State or Foreign				
3 should	E O	9e. FACILITY NAME (# not institution, give street end number) 1405 Forge Avenue	22		N OR LOCATION OF D		Balto.					
3 1, 2,	٥	RESIDENCE OF DECEDENT										
permit, Pages	DIRECTOR	Maryland Balto. Cit	У 100	Balt	imore			IOd. INSIDE CITY LIMITS? I XYES 2 NO				
n. ansit perr	FUNERAL	1405 Forge Avenue			10f. ZIP CODE	21209	109. CITIZEN OF WHU	AT COUNTRY?				
215-0020 attending physician. ise as the bunal-transit	ВУ	1 Never Married 2 Married FORCES?	ENT EVER IN U.S. ARMED 1 YES 25 NO E WAR OR DATES	If yea,	PECENDENT OF HISPAI specify Cuben, Mexico (ES XIXNO Specific	NIC ORIGIN? (Specify Yes an, Puerto Rican, etc.) fy:	or No— 14. RACE — Black, 1 Specify:	- American Indian, White, atc. White				
21 0 0 0	COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or	(Give kin	NT'S USUAL OCCUPY d of work done during OT use retired.)		16b. KIND OF BUS						
AND 2 the hospital detached to once.	MP	8	Но	memaker		Ow	n Home					
by the	BE CO	17. Father's NAME (First, Middle, Lest) George Arthur Dicker	rson		16. MOTHER'S NA	ME (First, Middle Maiden S Ilie Jane	Keith					
	10	Lucinda Herschberger	19b. MA	405 For	ge Aven	Route Number, City or Town ue Baltim	ore, MD	21209				
T pa		20a. METHOD OF DISPOSITION 1 Spuriat 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	cemetery, cremator	ATE OF DISPOSITION or other place) Church			cation - City or Town					
ALTIN death. Pag thereal dis funeral dis f		21. SIONATURE OF FUNERAL SERVICE LICENSEE	1	22. NAME	AND ADDRESS OF FA			-				
BAL ter deat the fun mal.	i	View Henss	reculi			Road Bal		21211				
tely filled in by nation, or remo		23. PART I. Enter the disease, or complications to shock, or levert failure. List only one of IMMEDIATE CAUSE (Final disease or condition resulting in deeth)	hat/saused the death. euse pn eech line. YG GAGG TO OR AS A CONSCOURN	1	mode of dyling, suc	h as cardlec or respir	atory errest,	Approximate Interval Between Onset and Dasth				
certificate be executed by physician and the Hygiene prior to burner other traumatic	CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
the death y the attended Mental H		DART II Other elgoificant conditions contribution	to death had not be									
requires that it een signed by of Health and shows any it	: MEDICAL	PART II. Other significent conditions contributing DID TOBACCO USE CONTRIBUTE TO C		YES NO		PERFORI	NO O	VERE AUTOPSY FINDINGS MILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO				
	IAN	25. WAS CASE REFERRED TO MEDICAL		DEATH (Check only or		N L]						
SICIAN: The certificate the State , or Item	SIC	EXAMINER? 1 TES 2 NO 1 Inpetient 2	□ ER/Outpatient 3 □ Do	OTHER:	ome 5-5 Residence	6 Other (Specify)						
PHY this the C	BY PHYSICIAN:	27. MANNER OF DEATH 1 Natural 5 Pending (Month) 2 Accident Investigation	OF INJURY 28b Day, Year)	TIME OF 28c. I	NJURY AT WORK? YES 2 NO	28d. DESCRIBE HOW IN	JURY OCCURED					
OR ATTENDING DIRECTOR; After Pours after death item 28 is ma	ETED 6	3 Suicide a Could and 28e. PLACE	OF INJURY — At home, fa g, atc. (Specify)	rm, street, factory, of	fica	281. LOCATION (Street as City or Town, State)	nd Number or Rural Rou	ite Number,				
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	COMPLE	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of						and manner as stated.				
TO THE HOSPITAL TO THE FUNERAL be filed within 72 IMPORTANT: If	BE	296. SIGNATURE AND TITLE OF CERTIFIER	und		29c. LICENSE NUI		29d. DATE SIGNED (M					
10	5	30. NAME ARDADDRESS OF PERSON WHO COMPLETED CA		Type, Print)		. Balto. 7						
		31. DATE FILED (Month, Day, Year) 32. REGIST	RAR'S SIGNATURE	U		,	7.00	•				
		The state of the s	A CONTRACTOR OF THE PARTY OF									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HUSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 15 hours after death. Page 6 may be retained by the hosp TO THE FLINERAL DRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached by the state of the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGII			
200	1. DECEDENT'S NAME (First, Middle, Last)	Myrtle Luc	cinda H	amer		2. DATE OF DEATH MONTH	DAY YEAR		
0.00	4. SOCIAL SECURITY NUMBER 214-20-1762	1 □ M 3x1x F	(in yrs. lest birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	July 6 7. DATE OF BIRTH (Month, Day, Year) NOV 7,	Cou	3:10 AM M ITHPLACE (State or Foreign aryland	
OR	9a. FACILITY NAME (If not institution, give st 3737 Elm Aver			96. CITY, TOWN O	ltimor	EATH E	9c. COUNTY OF		
DIRECTOR	10e. STATE 10b. COUNTY Maryland	Balto. Ci	ity 10c. CITY	, TOWN OR LOCAT	ion Ba	ltimore	10d. INSIDE CITY LIMITS?		
	10e. STREET AND NUMBER	737 Elm Ave		10	. ZIP CODE	21211	10g. CITIZEN OF	MXYES 2 NO F WHAT COUNTRY?	
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	U.S. ARMED	If yes, sp		NIC ORIGIN? (Specify in, Puerto Rican, etc.)	Bi	CE — American Indian, sck, Whita, etc.	
LETED	15. DECEDENT'S EQUI (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)		USUAL OCCUPATION PORT MODEL PROPERTY OF THE PR	st of working	166. KIND OF BUSINESS/INDUSTRY OWN Home			
COMPLET	17. FATHER'S NAME (First, Middle, Lest)	George S.			16. MOTHER'S NA	ME (First, Middle, Maid lsie M.	en Surname)		
O BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a		Route Number, City or 1			
=	Donald V. Hamer		3737	Elm Av	enue l	Baltimor	e, Mary	land 21211	
	20a. METHOD OF DISPOSITION XS Buriel 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) Good Shepherd Cemetery 7/10 Ellicott City, MD								
	21. SIGNATURE OF FUNERAL SERVICE LIC	ensee Carpin	tu	Burg		ss Funer Road Ba			
	23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, auch as cerdiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. OUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
7	PART II. Other significant conditions	contributing to deeth b	ut not resulting i	n the underlying	cause given in	Part I. 24a. WAS	AN AUTOPSY 2-	4b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO	
MEDIC	1 YES 2 NO COMPLETION OF CAU OF DEATH? 1 YES 2 NO 1 YES 2 NO							OF DEATH?	
TOICIAN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 125. WAS CASE REFERRED TO MEDICAL 26. PLACE OF GEATH (Check only one) EXAMINER?								
2	1 VES 2 NO 27. MANNER OF GEATH	1 Inpetiant 2 ER/Outp	etlant 3 DOA	OTHER:		6 Other (Specify)			
	1 Natural 5 Pending Investigation	(Month, Day, Year)	INJ	M 1 1	RK? 'ES 2 NO	284. DESCHIBE HO	V INJURY OCCUREO		
	3 Suicide 4 Homicide 8 Could not be determined 26a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 26b. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
MPL		CIAN: To the best of my knowl						o(a) and manner as stated	
3	296 SIGNATURE AND TITLE OF CERTIFIER	Fern	MO		29c. LICENSE NUN	ABER O	29d. DATE 91GNI	ED/Month, Day, Year)	
	30. NAME AND ADDRESS OF PERSON WHO BUTSY A Tay. 31. DATE FILE OF THE OF	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Rd. Bo	Homowe	Mid	1211	. •	
Ì	31. DATE FILE JUL 0" 71995	PEGIS AR'S SIGN	Terles.			1			



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	TATE OF MARYLAND /	DEPARTME	NT OF H	EALTH AND I	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)	NAME (First, Middle, Lest) 2. DATE OF DEATH 3.1							
		Elizabeth Hopp June 28, 1995							
	212-09-6831	212-09-6831 1 M 2XXF 85 YRS. MONTHS DAYS HOURS MIN. MAY 15, 1910 MATYL							
۳ ا	9a. FACILITY NAME (If not institution, give street a 2628 E. Mwa Street		9b. C		MOTE.	EATH	9c. COUNTY OF		
5	RESIDENCE OF DECEDENT	<u>a</u>					N/c	ı.	
FUNERAL DIRECTOR	Maryland 10b. county	N/A	10c. CITY, TOW	n or locat Ltimor				10d. INSIDE CITY LIMITS? 1 YES 2 \(\text{\text{\text{NO}}} \) NO	
RAL	10e. STREET AND NUMBER	<i>-</i>		101.	ZIP CODE			WHAT COUNTRY?	
JNE	2628 E. Mura Stree	WAS DECEDENT EVER IN U.S. AR	RMED	13. WAS DEC	21213	IIC ORIGIN? (Specify Yes	U. S.	CE — American Indian,	
ВУ	1 Never Married 2 N Married	FORCES? 1 TYES 2 TI IF YES, OIVE WAR OR DATES	NO		city Cuban, Maxica	n, Puerto Rican, etc.)	Bla	lek, White, etc.	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade compa	leted) (G	ECEDENT'S USUAI	ne durina mos	N st of working	16b. KIND OF BUS	SINESS/INDUSTRY	***************************************	
PLE	Elementary/Secondary (0-12) Col 6th grade	flege (1-4 or 5+)	Homemak	d.)	-003	0	n Home		
MO	17. FATHER'S NAME (First, Middle, Last)		nomemak	.ei	18. MOTHER'S NA	ME (First, Middle, Maiden			
BE C	Harry Thomas				Carol	ine Wenzel			
2	190. INFORMANT'S NAME (Type/Print) William A. Hopp (So					Number, City or Tow		1064	
	20e. METHOD OF DISPOSITION	20b. PLACE	AND DATE OF DISE	OSITION (Na	ne oi	rettsville	CATION City or 1	Town State	
	1 💢 Buriel 2 🗆 Cremation 3 🗆 Removal to 4 🗆 Donation 5 🗀 Other (Specify)	rom Stata cemetary, cre	metory or other pie	Cemet	ery 7/1	195 Bal	ltimore, Maryland		
- 1	21. SIGNATURE OF FUNERAL SERVICE LICENSE	E	1	22. NAME AN	D ADDRESS OF FA	neral Home			
	11111111			3331	Brehms	Lane, Balt	imore, 1	Md. 21213	
	23. PART i. Enter the diseases, or complete shock, or heart fallure. Liet of	licetions that caused the de only one cause on each line	eth. Do not en	ter the mod	de of dying, auci	n aa cardiec or reapi	ratory arrest,	Approximata interval Batween	
	IMMEDIATE CAUSE (Final disease or condition resulting in death) e. frobable stroke Due to (or as a consequence of):								
	DUE TO (OR AS A CONSEQUENCE OF): Cerebrova scular discuse								
ĕ	Sequentially list conditions, oue to (or as a consequence of):								
ICA	cause. Enter UNDERLYING CAUSE (Disease or injury c. Diabetes me //i fus							years	
CERTIFICATION	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST								
	PART ii. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24e, WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS								
ICAL	PERFORMED? ANA								
MED						1 YES 2	NO	OF DEATH? 1 □ YES 2 □ NO	
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBU	TE TO CAUSE OF DEA	TH YES	NO 🖸	UNCERTAIN	10			
S		SPITAL:	E OF DEATH (Che	ER:					
HX	27. MANNER-OF OEATH	Inpatient 2 ER/Outpetient 3 28a. DATE OF INJURY	28b. TIME OF	28c. INJU	5 Nasidence	6 Other (Specify) 28d. OESCRIBE HOW II	NJURY OCCURED		
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	1 Y	RK? ES 2 NO				
COMPLETED	3 Sulcide 8 Could not be detarmined 28e. PLACE OF INJURY — At home, term, street, tectory, office building, atc. (Specify) 28t. LOCATION (Street and Number or Rural Route In City or Town, State)							Route Number,	
2		To the best of my knowledge, de							
SOS	one) 2 MEDICAL EXAMINER: On	the basis of examination and/or i	investigation, in m	y opinion, de	ath occured at the	time, data and place, en	d due to the cause	(s) and manner as stated.	
BE	296. SIGNATURE AND TITLE OF CERTIFIER SUL B BASS	AM.			29c. LICENSE NUM	9 9		D (Month, Day, Year)	
٩	30. NAME AND ADDRESS OF PERSON WHO CON	MPLETED CAUSE OF DEATH (ITER	M 27) (Type, Print) F. Mon.	unent !	St. Rm 80	40 Bolt	more in	1 21205	
		92. REGISTRARY SIGNATURE	4 100		7	7 34 11/	The Popular	1 2 2 2 3	
	21.0 10. 10.00	p2. REGISTRAN SIGNATURE	t, Mon	ment	st, Rm 80	60 /54lt	more m	121	

retained by the hospital or attending physician. 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020 page 5 should hours after death. Page 6 may be funeral director, ben signed by the attending physician and completely filled in by the of Health and Mental Hygiene prior to burial, cremation, or removal. executed

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DIVISION OF VITAL RECORDS, P.O. BOX 68769	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with
VISION	ATTENDING
5	8
_	HOSPITAL

peed

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH David Fleming Hambleton 1995 July 6, 10:00 A.M.M 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. Oct. 9, 291-30-3495 1 🔯 M 2 🗌 F 57 VRS 1937 Kentucky 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 6707 Park Hall Drive Laurel Prince George RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Maryland Prince George Laure1 1 TES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6707 Park Hall Drive 20707 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 Y YES 2 NO IF YES, DIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 D Married If yes, specify Cuban, Maxican, Puerto Rican, atc.)

1 YES 2 NO Specify: BY 3 Widowed 4 Divorced Specify: White COMPLETED 15. DECEDENT'S EDUCATION ecity only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify Elementary/Secondary (0-12) College (1-4 or 5+) 12 4+ Executive U.S. Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at James A. Hambleton Margaret Fleming BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 6707 Park Hall Drive, Laurel, Maryland 20707 Mary Hambleton must be 20a. METHOD OF DISPOSITION
1 □ Burial 2 □ Cremetion 3 □ Ramoval from State
4 □ Donation 6 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE Baltimore-Washington Crem. 7-7 Laurel, Maryland event, the medical examiner 21, SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Md. 20707 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such se cardiec or reepiratory screet, shock, or heart fellure. List only one ceuse on each line Interval Between IMMEDIATE CAUSE (Finel Onset and Death disease or condition Pancreatic Cancer to the lives Metastatic reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse Dr Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in desth) LAST 6 Injury, PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? shows any 1 TES 2 1 NO 1 - YES 2 PNO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES YOU UNCERTAIN certificate has been the State Dept. of PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem HOSPITAL: OTHER: 1 TES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 Masidence 8 - Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26b. TIME OF 28d. DEŞCRIBE HOW INJURY OCCURED this c marked, 1 Natural TO THE HOSPITAL OR ATTENDING PH TO THE FUNERAL DIRECTOR: After this be filed within 72 hours after death w IMPORTANT: If Nem 28 is marke 1 YES 2 NO BY Investigation 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be COMPLETED 4 Homicide 29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, date and place, and due to the cause(s) end manner as stated. (Check only one) 2 __ MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE 038509 ► July 7th 1995 Kindult 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

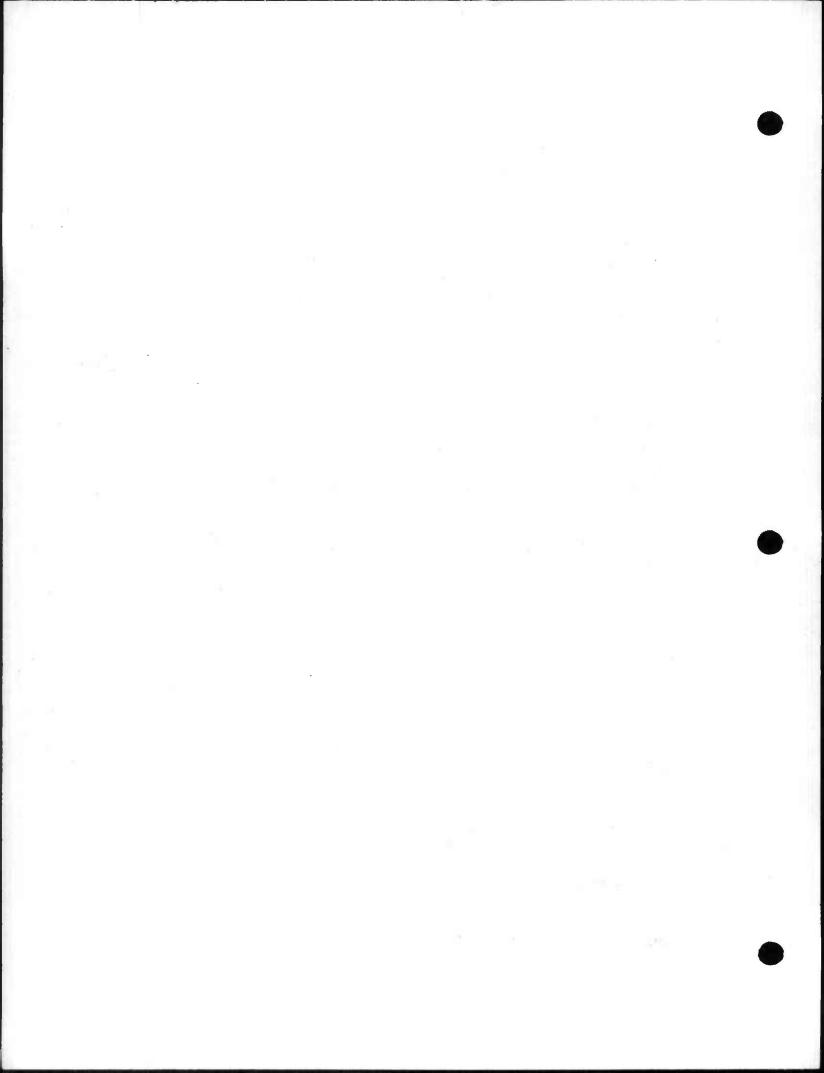
lumbin MD

NICHOLAS KOWFREIN FOS 11065 LIHLE Parturent Pkny

32. REGISTRAR'S SIGNATURE

31. DATE FILED (Month, Day, Year)

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		1 - FOR STATE REGISTRAR	OF MARYLAND / DEPARTMENT CERTIFICAT	TOF HEALTH AND ME	NTAL HYGIENE REG. NO.				
		1. DECEDENT'S NAME (First, Middle, Last)	Hodgson		DATE OF DEATH DAY	YEAR 3. TIME OF DEATH			
		4. SOCIAL SECURITY NUMBER 198-20-6654 9. FACILITY NAME (If not institution, give street and number)	66 YRS. MONTH			8. BIRTHPLACE (State or Foreign Country) Pennsylvania			
	DIRECTOR	North Arund.	el Hosp G	len Bur	-vie	AA			
	- 0	MD Anne Arun	idel Odent		l m- orr	10d, INSIDE CITY LIMITS? 1 XYES 2 NO ZEN OF WHAT COUNTRY?			
	FUNERAL	520 R. N. Patuxent		21113		JSA			
i	à	1 Never Merried 2 Merried FORC	DECEDENT EVER IN U.S. ARMED ES? 1 YES 2 YNO B. GIVE WAR OR DATES	3. WAS DECENDENT OF HISPANIC It yee, specify Cuban, Mexicen, F 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
	COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondery (0-12) College ((1-4 or 5+) 18a. DECEDENT'S USUAL (Give kind of work don life. Do NOT use retired Homemaker	e during most of working	16b. KIND OF BUSINESS/IND				
	BE COM	17. FATHER'S NAME (First, Middle, Last) Norman Stiffler	18. MOTHER'S NAME	AME (First, Middle, Malden Surneme) Buring					
notifie	2	190. INFORMANT'S NAME (Type/Print) Ramon E. Hodgson		ss (Street and Number or Aural Acut N.Patuxent R					
or removal. medical examiner must be		20s. METHOD OF DISPOSITION 13 Burlant 2 Cremeation 3 Demoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of capacity or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of capacity or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of capacity or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of capacity or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of capacity or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of capacity or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of capacity or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of capacity or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of capacity or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of capacity or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of capacity or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of capacity or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of capacity or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of capacity or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of capacity or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of capacity or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of capacity or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of capacity or other place) 20b. PLACE AND DATE OF D							
removal.		23. PART i. Enter the diseasea, or complicati	04/1	ardesty Fune	venue, Anna	polis, MD			
		shock, or heart failure. List only immediate CAUSE (Final disease or condition resulting in death)	one cause on each line. Multiple But To (on as a confequence on):		a cardiac or reapiretory arr	est, Approximate interval Between Onset and Daath			
Hygiene prior to buris or other traumatic	CERTIFICATION	Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):						
shows any injury.	EDICAL C	PART II. Other significant conditions contribu	ating to death but not reaulting in the	underlying cause given in Par	1 YES 2 YO	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
23 sho	Ξ	DID TOBACCO USE CONTR	BUTE TO CAUSE OF DEA	TH YES NO	<u> </u>	1 TYES 2 NO			
or Item	2		lant 2 ER/Outpatient 3 DOA 4 N	26. PLACE OF DEATH (Check ER: ursing Home 5 - Residence 6					
marked,	6	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 28e.	DATE OF INJURY (Morth, Day, Yeer) 13 3 5 5 13 8 CM PLACE OF INJURY — At home, term, street, fi	WORK? 1 ☐ YES 2 X NO	DESCRIBE HOW INJURY OCCUPATION (Street and Number	Collision			
item 28 is		4 Homicide determined	building, etc. (Specify) Treet		City or Town, State)	No			
ANT: If its	COMPL	(Check only one) 2 MEDICAL EXAMINER: On the b	e beet of my knowledge, death occurred at the eale of examination end/or investigation, in m						
be filed within IMPORTANT:	K	299. SIGNATURE AND BITLE OF CERTIFIED	mother	D C6		E SIGNED (Montil, Day, Year)			
}		30. NAME AND ADDRESS OF PERSON WHO COMPUTED IN THE PROPERTY OF	TED CAUSE OF DEATH (ITEM 27) (Type, Print)	695 F	merica	21035			
		JUL U 1 1555							

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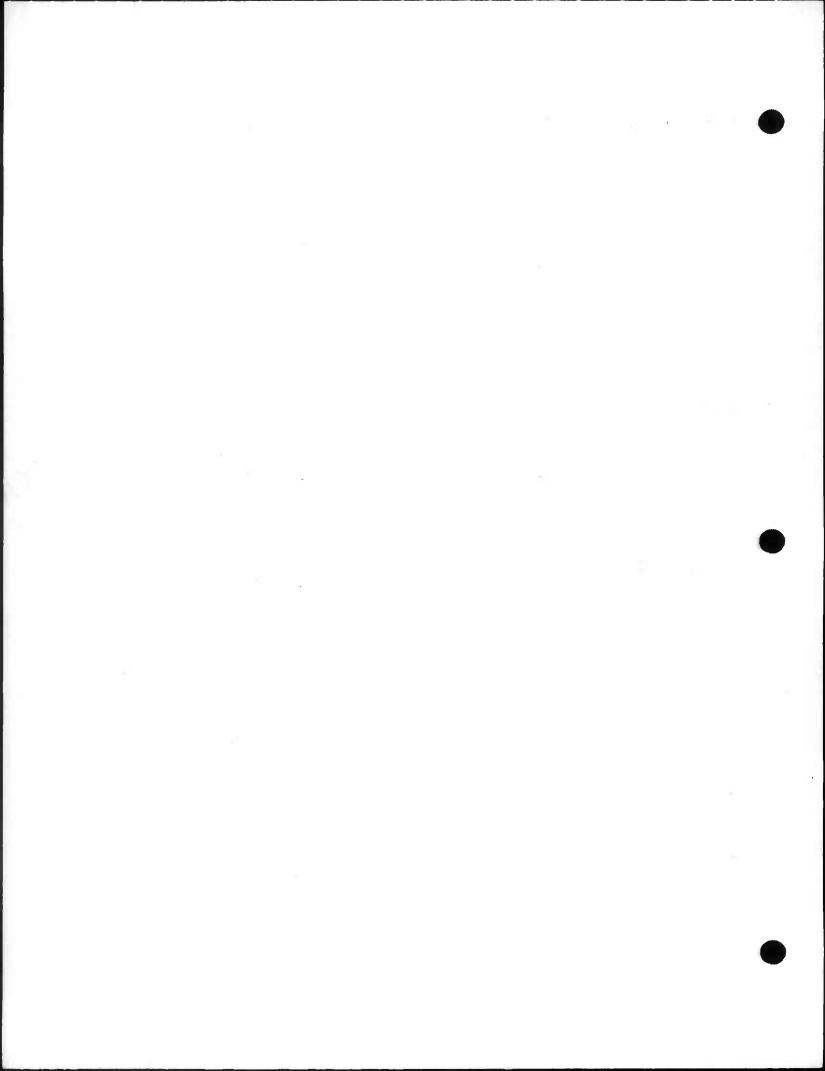
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAI REGISTRAR	ND / DEPARTM CERTIFIC	MENT OF H	EALTH AND I		GIENE			
9.9	1. DECEDENT'S NAME (First, Middle, Last) ALEXANDER F. JENKINS	•			2. DATE OF DEATH JULY 4, 1995 YEAR 2. TIME OF DE 9:50				
		5 SEY & AGE (in you lost highway) IT IMPER A VISA TO IMPER A VISA					8. BIRTH	PLACE (State or Foreign	
	217-09-5233 1\Q M 2 □ F 77	YRS.	NTHS DAYS	HOURS MIN.	(Month, Day, Y	7, 1917	Mic	higan	
H	98. FACILITY NAME (If not institution, give street and number) 3739 ELMLEY AVENUE		. city, town o Baltim	OR LOCATION OF DE	EATH	N/A	NTY OF DE	EATH	
S	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY					IN/A			
DIRECTOR	Maryland N/A		OWN OR LOCAT	ION				10d. INSIDE CITY	
	10e. STREET AND NUMBER	ball	imore 101	ZIP CODE		10g, CITI	ZEN OF W	1 X YES 2 NO	
FUNERAL	3739 Elmley Avenue			21213		u.s			
P.	11. MARITAL STATUS 1 Never Married 2 Married FORCES? 1 YES	J.S. ARMED		ENDENT OF HISPAN			14. RACE	- American Indian, White, etc.	
ВУ	3 💢 Widowed 4 Divorced IF YES, GIVE WAR OR DATE			2 NO Specify		(6.)	Specif		
	15. DECEDENT'S EDUCATION 1	8a. DECEDENT'S USU	JAL OCCUPATION	IN .	16b. KIND C	F BUSINESS/IND	USTRY	writte	
COMPLETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of work life. Do NOT use re-							
MP	5th grade	Highline	Atten			i & Ore	Comp	any	
	17. FATHER'S NAME (First, Middle, Last) Frank Jenkins				ME (First, Middle, N Prusko	laiden Surname)			
BE	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADI	DRESS (Street a	nd Number or Rural F		or Town State 7/o	Codel		
2	Linda J. Simmons (Daughter)			ed circle				014	
		LACE AND DATE OF D	SPOSITION (Na	me of	OATE 20	c. LOCATION — (City or Tov		
	4 Donation 5 Other (Specify)	aney val					ım, 1	Maryland	
	Service de la constante de la			nuner Ful					
4	Mall Supl	>		Brehms 1				. 21213	
								Approximate Interval Between	
	IMMEDIATE CAUSE (Fine) disease or condition								
	resulting in desth) a. // / CANAL INTROCULON DUST TO (OR AS A CONSEQUENCE OF):								
z	disease or condition resulting in desth) a. Myo candial intorction DUF TO (OR AS A CONSEQUENCE OF): Sequentisily list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):								
A T	If any, lesding to immediate course. DUE TO (OR AS A COUNTEQUENCE OF):								
RTIFICATION	CAUSE (Disesse or injury that initiated events OUE TO (OR AS A CO	ONSEQUENCE OF):					<u>-</u>		
H	resulting in death) LAST								
AL CE	PART II. Other eignificant conditions contributing to deeth but	not resulting in th	ne underlying	cause given in	Part I 24a W	AS AN AUTOPSY	245	WERE AUTOPSY FINDINGS	
/ N II	HBP CHF				PE	RFORMED?	1	AVAILABLE PRIOR TO COMPLETION DF CAUSE	
MEDIC					_ '''	ES 2 AND		OF DEATH?	
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF	DEATH YES	□ NO □	UNCERTAIN	4 D		1		
PHYSICIAN:	EXAMINET? HOSPITAL	PLACE OF DEATH (C	theck only one)						
7	1 Let YES 2 NO 1 Inpatient 2 ER/Outpatk 27. MANNER OF DEATH 26s. DATE OF INJURY	ent 3 DOA 4 D	Nursing Home	5 Residence					
	1 Natural 5 Pending (Month, Day, Year)	28b. TIME OF INJURY	WOI	PK? ES 2 NO	28d. DESCRIBE F	IOW INJURY OCC	URED		
B A	2 Accident Investigation 3 Suicide 8 Could not be	At home, farm, street		20 2 110	28f. LOCATION (S	treet and Number of	or Runal Ro	oute Number,	
☐ 4 Homicide detarmined City or Town, State)									
COMPLE	29e. CERTIFIER (Check only (Ch	gs, death occurred at	the time, date	end place, and dua	to the cause(a) en	d manner se atate	rd.		
	2 MEDICAL EXAMINER: On the basia of examination as	nd/or investigation, in	my opinion, de	ath occured at the	time, deta and plac	ce, end due to the	cause(a)	and manner as stated.	
RE C	28h. SIGNATURE AND TITLE OF CENTREE	1111	7	29c. LICENSE NUM	IBER	29d. DATE	SIGNED	Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH	WILL AUTOM OF THE PROPERTY OF		NZZ	417	0	710	6/95	
	Pital Dich	11 (1) (1) (1) (1) (1) (1) (1) (1) (1)	741	4 (1	Par. O	Ct 1	201	1 71210	
		IRE	2//	1)1,	aux)	by B	axi	- 4148	
	31. DATE FILED (Month, Day, Year)								



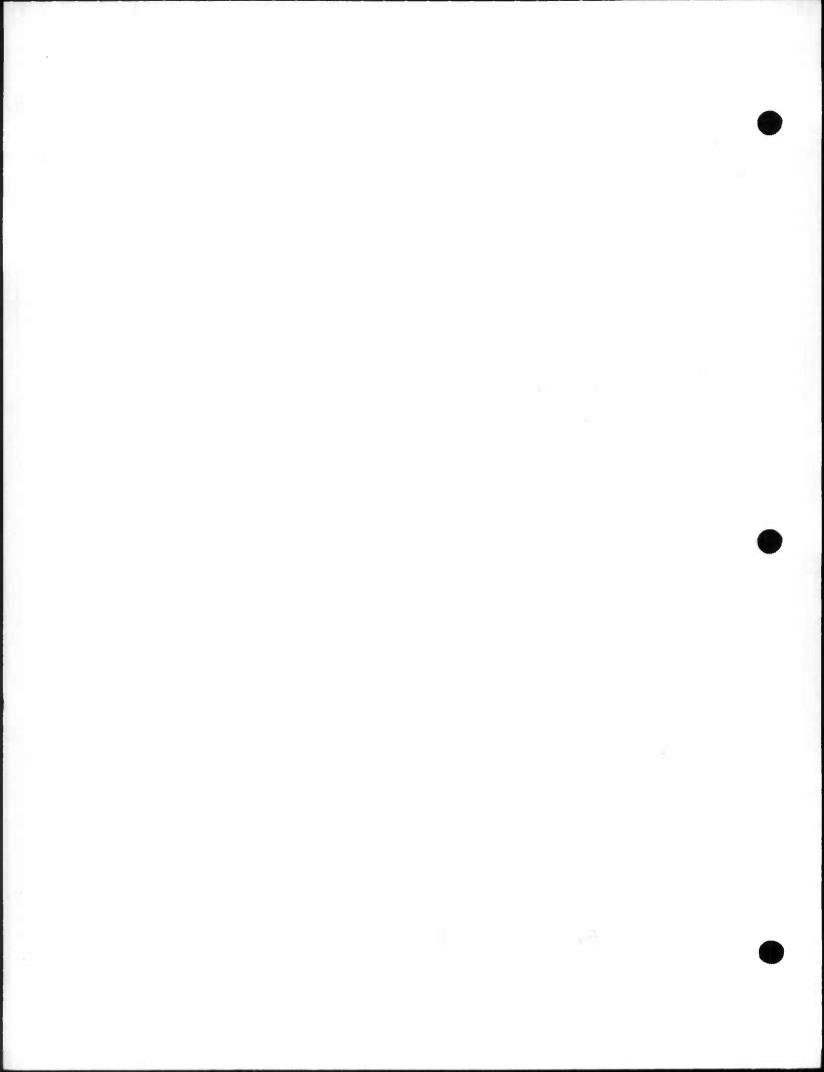
BALTIMORE, MARYLAND 21215-0020	24 hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should ith the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	the medical examiner must be notified at once,	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-rs hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fune be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: it tem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

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FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		OLITTI	TOATE OF	DLAIN	HEG. NO		
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH
	Foster A. JA	MONTH T DAY & YEAR 9 P					
		AGE (In yrs. last birthday)	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	6.	BIRTNPLACE (State or Foreign Country)
	212-60-9577 10/M2 OF	43 YRS.	MONTHS DAYS	HOUNS MIN.	8275		MA
	9a. FACILITY NAME (If not institution, give street and number)		9b CITY TOWN	OR LOCATION OF DE		9c. COUNTY	OF DEATH
œ			R.	1 . 4	DATE:		
9	SiNai HOSPItal		DKC	TIMOR	6	NI	A
DIRECTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY						
2	10a. STATE 10b. COUNTY	10c. CIT	Y, TOWN OR LOCA	ATION			10d. INSIDE CITY LIMITS?
ā	Mal	R	AUTLI	MORE			1 YES 2 NO
7	10e. STREET AND NUMBER			Of, ZIP CODE		100 CITIZE	N OF WHAT COUNTRY?
2	2700 CLASSEN AU	B. Zndf) .	2121			
y		E' Chord	L1005	2121	2	as	-04
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT E	VER IN U.S. ARMED			NIC ORIGIN? (Specify Yes	or No- 14	. RACE — American Indian,
	1 Never Married 2 Married FORCES? 1 IF YES, GIVE WAR			pecify Cuban, Mexica S 2 ZANO Specifi	n, Puerto Rican, atc.)		Black, White, atc.
B	3 Widowed 4 Divorced	OII OAI CO	'''	Specific Specific	у.		Specify: Alack
۵	15. DECEDENT'S EDUCATION	16a. DECEDENT'S	Hellal Coolina	ION	T		Biriot
H	(Specify only highest grade completed)	(Give kind of s	work done during m		16b. KIND OF BUS	SINESS/INDUS	IRY
ا ۳	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT us	•		11		\sim
6	10th NA	LAB	oler		LANDS	CAPIN	G 60
COMPLETED	77 FATHER'S NAME (First, Middle, Last)			16. MOTHER'S NA	ME (First, Middle, Maiden	Sumame)	
	KOBERT I. JACKSON	.)		Pina	0 - TU T		
BE				CLIZA	DEIH 7	のまるの	
2	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING	ADDRESS (Street	and Number or Rural	Route Number, City or Tow	n, State, Zip Co	00), 21215
-	ELLEN JACKSON	12701	CLAS	SEN AU	5. 2nd+1	DOR 8	Salto. Md.
	20g. METHOD OF DISPOSITION	20b. PLACE AND DATE		-		-	or Town, State
	1 Burial 2 Cremation 3 Removal from State	cometary, cremetoly or o	ther plece)	11 \) I	or lown, state
	4 Donation 5 Other (Specify)	King Me	MOZIAL		-J-62 E	x 1tc	Ma.
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	,)	22. NAME A	ND ADDRESS OF FA	CILITY	111/00	+ 21215
	▶ PILLI T. II	- A A A	MARC	y wins	ral tone-	WES	, eccis
	TOMOS P P	Card	430	OWab	ash the.	Halo	to Md.
	23. PART I. Enter the disease, or complications that c ahock, or heart failure. List only one cause	eused the deeth. Do r	not enter the m	ode of dying, suc	h aa cardiec or respi	ratory srreat	
	IMMEDIATE CAUSE (Finel	on each line.					interval Between Onset and Death
	disease or condition	hahal	1. 1.1	O •			Oliset and Death
- 1	resulting in death)	AS A CONSEQUENCE OF	ungal	ano.			
			F):				
Z	- H.I.	V +.					
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	AS A CONSEQUENCE OF	F):				
4	cause. Enter UNDERLYING						1
E I	CAUSE (Disease or injury that initiated events DUE TO (OI	AS A CONSEQUENCE OF	F):				
EI	resulting in death) LAST						i 1
	d						
	PART II. Other algorificant conditions contributing to de	ath but not regultion	le the underful		Post I as una su		
MEDICAL	The state of the s	stil but not resulting i	in the dilderlyii	ig cause given in	Part I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
8 1					1 YES 2	tho	COMPLETION OF CAUSE OF DEATH?
<u>u</u>				/	_	-	
	DID TOBACCO USE CONTRIBUTE TO CAUS	E OF DEATH VE	CILVOI	LINICEDTAL			1 TES 2 NO
2					ч 🗆 📗		
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	26. PLACE OF DEAT)			
S	I HOSFITAL.	R/Outpatient 3 DOA	OTHER:	ne 5 🗆 Residenca	6 Other (Specify)		
PHYSICIAN:	27. MANNER OF DEATH 26s. DATE OF IN.	IURY 26b. TIM		JURY AT	26d. DESCRIBE HOW II	A HIRY OCCUR	ED
	1 Natural 5 Pending (Month, Day,	Year) INJ	URY W	ORK?	acc. ocyclinoc flori ii	100111 000011	
BY	2 Accident Investigation			YES 2 NO			
	building. etc	JURY At home, term, a	street, factory, offi	Ca	281. LOCATION (Street a	nd Number or	Rural Route Number,
2	4 Nomicide determined	144000,			City or Town, State)		
Solicide Solicide							
ᅙ	(Check only 1 CERTIFYING PHYSICIAN: To the best of my						ŀ
§	one) 2 MEDICAL EXAMINER: On the besie of exert	ination and/or investigation	n, in my opinion,	death occured at the	time, date end place, an	d due to the c	suse(s) and manner ea stated.
				T			
					med	204 DATE OF	
w II	296. SIGNATURE AND TITLE OF CERTIFIER D 2/73	-	ν .	29c. LICENSE NUN		290. DATE SI	GNED (Month, Day, Year)
H	296. SIGNATURE AND TITLE OF CERTIFIER D 2/73	-	Lypician		730	DATE SI	GNED (Month, Day, Year) 7 2 95
w II		-	Duylua			>	
H	29b. SIGNATURE AND TITLE OF CERTIFIER D 2/73	OF DEATH (ITEM 27) (Type,		D217		b bare si	
H	29b. SIGNATURE AND TITLE OF CERTIFIER D2/73 AND WHO WO 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF Tariq Khan, M.D.; Sinai Hos	OF DEATH (ITEM 27) (Type, spital of B.		D217		>	
H	29b. SIGNATURE AND TITLE OF CERTIFIER D 2/73	OF DEATH (ITEM 27) (Type, spital of B.		D217		>	

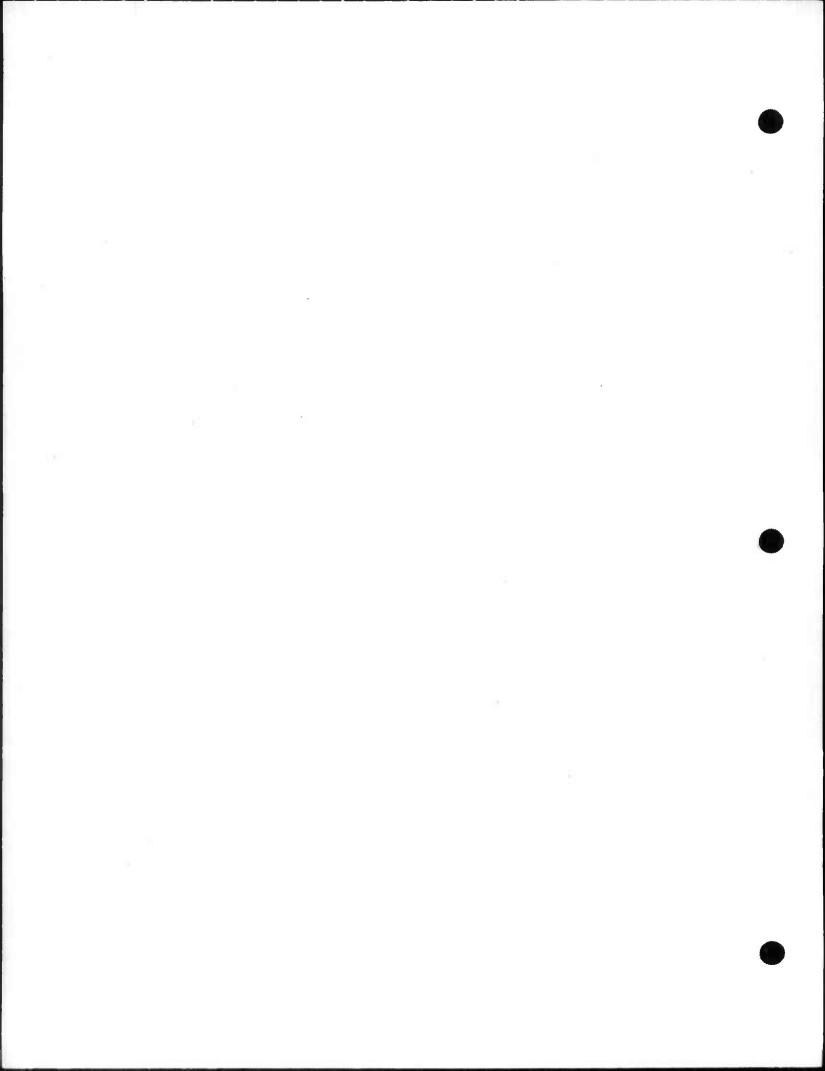


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	TO THE LINCOLTA IN A PITEINING DUVERIAL The Law securiors they the death confidence to monocolour which of a security of the s
	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remonal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLA		MENT OF H		MENTA	L HYGIEN				
	1. DECEDENT'S NAME (First, Middle, List) MARY KORENCZUK					2. DATE	OF DEATH		/EAR	TIME OF DEA	тн Ю. м
	The state of the s	6. AGE (III	n yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE (Mont)	OF BIRTH h, Day, Year) il 14.			ACE (State or F	
OR	90. FACILITY NAME (If not institution, give street 3549 Shannon Drive			96. CITY, TOWN O	OR LOCATION OF DI		11,	9c. COUNTY			
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY			TOWN OR LOCAT	TION				10	d. INSIDE CIT	Υ
	Maryland N/A 100. STREET AND NUMBER		Bal	timore 101	. ZIP CODE			10g. CITIZE		YES 2	NO
FUNERAL	3549 Shannon Drive	2. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC	21213	MIC OBIGIN	17 (Specify Vo	U.S.		American Ind	(i)
В	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 X NO	if yes, sp	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:				Black, W Specify:	white	ian,
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12)	TION mpleted) College (1-4 or 5+)	16a. DECEDENT'S U (Give kind of wo life. Do NOT use	ISUAL OCCUPATION done during mo retired.)	ON st of working	16b	KIND OF BU	SINESS/INDUS	TRY		
MPL	N/A N	V/A	Homemak	er			Own Ho				
	17. FATHER'S NAME (First, Middle, Last) Artemij Soroka				18. MOTHER'S NA Audokí			-			
TO BE	19a. INFORMANT'S NAME (Type/Print)				nd Number or Rural						
	Adam Korenczuk (Sc		J GLE		nor Cour			Md.			
	1 🖾 Buriel 2 🗆 Cremation 3 🗆 Ramova 4 🗆 Donation 5 🗀 Other (Specify)	Pa	rtery cremetory or oth	emetery		7/5/9	5 Ba	utimo)			nd
	21. SIGNATURE OF FUNEBAL SERVICE LICEN	SEE Call 6	<	SCHUM 3331	id address of fa unek Fun Brehms L	eral ane.	Home Balti	more.	Md.	21213	3
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reepiratory arrest, abock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due To (OR AS A CONSEQUENCE OF):										
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):										
MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause give					se given in Part I. 24a. WAS AN AUTOF PERFORMED? 1 YES 2 NO			COI OF	RE AUTOPSY F MILABLE PRIOR MPLETION OF (DEATH?	CAUSE
AN:	DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL		DEATH YES		UNCERTAIN	v 🗆					
PHYSICIAN:	EXAMINER?	OSPITAL:		OTHER:	s 5 ☐ Residence	6 Other	r (Specify)				-
	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJUI	OF 28c, INJI	URY AT RK?			NJURY OCCUR	ED		
red BY	2 Accident Investigation 3 Suicide 8 Could not be detarmined	28e. PLACE DF INJURY - building, atc. (Specif	Al home, farm, str		ES 2 NO	281. LOCA	ATION (Street or Town, State)	and Number or	Rural Route	Number,	
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAL ONE) 2 MEDICAL EXAMINER: C	N: To the best of my knowle	age, death occurred	at the time, data in my opinion, de	and place, and due	to the cau	se(a) and made	nner as stated.	ause(a) an	d menner as a	fated.
BE	296. SIGNATURE AND THE OF CERTIFIER	Min	ירן כבי	<i>D.</i>	29c. LICENSE NUM					inth, Day, Year)	
10	Leopoldo Gruss	M.D. 405	Stan	mers	Run Ru	ood	BA	170 n	10	212	2/
	31. DATE FILED (Month), Day, Your) 32. REGISTRAR'S SIGNATURE										



BALTIMORE, MARYLAND 21215-0020

DIRECTOR

FUNERAL

BY

COMPLETED

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

nce	er must be notified at once.	ent, the medical examir	MPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notifii	m 23 shows any injur	is marked, or iter	APORTANT: If Item 28
		cremation, or removal.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.	e Dept. of Health and Me	er death with the State	filed within 72 hours aft.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-fran	I director, page 5 should be du	pletely filled in by the funera	attending physician and com	has been signed by the	R: After this certificate	THE FUNERAL DIRECTOR
e hospital or attending physician.	The law requires that the death certificate be executed within amounts after death. Page 6 may be retained by the hospital or attending phy	within amounts after death.	leath certificate be executed	he law requires that the d	NDING PHYSICIAN: II	THE HOSPITAL OR ALTENDING PHYS

CERTIFICATION

PHYSICIAN: MEDICAL

ВУ

COMPLETED

BE

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THEODORE E. EVANS MD

22. REGISTRAN'S SIGNATURE

31. DATE FILED (Month, Day, Year)

Item!9.c G-film 725 per F.H 7/7/95P.C 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH WELDON W. KOENIG 630 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign Oct. 26, 220-03-8721 1XXM 2 □ F MONTHS DAYS HOURS 75 VRS Kentucku 1919 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c SOUNTY OF DEATH Atlantic General Hospital Berlin Worcester RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore Maryland Perry Hall 1 TYES 2 ND 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 9915 Richlun Drive 21128 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FDRCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES Spochy: White 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade complete 160. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NDT use retired.) ntery/Secondary (0-12) College (1-4 or 5+) 12th grade Machinist Radiator Company 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) William Koenia Bertha Kummer 19e, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen B. Koenig (wife) 9915 Richlyn Drive, Perry Hall, MD 21128 20e. METHOD OF DISPOSITION
1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE | 20c. LOCATION — City or Town, State Green Mount Crematory 7/69 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADORESS OF FACILITY Schumuner Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 23. PART I. Epter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximata ock, or heart failure. List only one cause on each line. Intarval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition CARDIAC ARRES

DUE TO (OR AS A CONSEDUENCE OF): reaulting in death) OUR DIVARY ATHEROSCLEROSS TORCLUSION Sequentially list conditions, If any, leading to immediate C. ARIERIOSCLEROTIC CARDIOVASCULAR
DUE TO (DR AS A CONSEDUENCE DE): cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to death but not reaulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? HYPERTENSION 1 TES 2 NO 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🔼 UNCERTAIN 🗆 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TYES 2 NO ☐ Inpatient 2 ☐ ER/Outpetient 3 XDOA 4 - Nursing Nome 5 - Residence 8 - Other (Specify) 27. MANNER DF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO 2 Accident 28e. PLACE DF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street end Number or Rural Route Number, City or Town, State) 6 Could not be 4 Nomicide 1 X CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated. 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE DF CERTIFIER 29d. DATE SIGNEO (Month, Day, Year) 290-LICENSE NUMBER D01340 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

9660 BELAIR Rd BALTO Md 21236

TO BE COMPLETED BY FUNERAL DIRECTOR

Item16a,Fi1m725,7	/7/95,1t)	0 20034	
1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
REGISTRAN CERTIFICATE OF DEATH REG. NO.									
MAITH BAY YEAR S. TIME OF CEATH									
		KELLER				JUNE 25	199		
4. SOCIAL SECURITY NUMBER 217-11-9668 5. SEX 1 M 2 F 8. AGE (In yrs. last birthday) F UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH AGORD, Days Nourillow Nouri									
9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH									
GOOD SAMARIT	'AN HOSP	ITAL		BALT	IMORE C	ITY		n/a	
10a. STATE 10b. COUN	TY		10c. CITY	TOWN OR LO	CATION			10d. INSIDE CITY	
	/a			BALT	IMORE		_	1 YES 2 NO	
100. STREET AND NUMBER 62 LANDMAR	K COURT				101. ZIP CODE 2122	1	-	TED STATES	
11. MARITAL STATUS	12. WAS DECEDER	IT EVER IN U.S. AR	MED	13. WAS	DECENDENT OF HISPA	NIC ORIGIN? (Specify Yes	or No.	14. RACE — American Indian,	
Never Married 2 Merried 3 Merried 2 Merried 3 Merried 3 Merried 3 Merried 3 Merried 4 Divorced 1 Merried 2 Merried 1 Merried 1 Merried 1 Merried 1 Merried 1 Merried 2 Merried 1 Merried 2 Merried 1 Merried 2 Merried 1 Merried 2 Merried 2 Merried 1 Merried 2 Merried 2 Merried 3 Merried 2 Merried 3 Merried 3 Merried 2 Merried 3									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY									
Elementary/Secondary (0-12) College (1-4 or 5+) 6 years FIN. College (1-4 or 5+) FIN. College (1-4 or 5+) FIN. Company TRIVER DRIVER TRANSPORTATION COMPANY									
17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	AME (First, Middle, Maiden		IN CUMPANY	
EZRA DAHN	KELLER		_		LOUIS	E BROWN			
190. INFORMANT'S NAME (TYPO/Print) 3 SAMUEL DAHN NWOB			62	LANDM		Acute Number, City or Tow T, BALTIMOR		code) RYLAND 21221	
20a. METHOD OF DISPOSITION		20b. PLACE	AND DATE OF	F DISPOSITION	(Neme of	DATE 20c. LO	CATION — C	Ity or Town, State	
1 C Buriet 2 Cremetion 3 Re 4 Donation 5 Other (Specify)		Cernetery Cre	FERN oth		CEMETERY		TONS	VILLE,MD	
·Bemad,	o gin	m		WM.		FH1101			
23. PART i. Enter the diseases, or shock, or heart feilure	complications the	t caused the de	ath. Do no	ot antar tha	mode of dying, suc	th as cardiac or reapi	ratory arre	Approximate interval Between	
IMMEDIATE CAUSE (Final	D.		4	14.	~ 1	1-		Onset and Death	
diseese or condition resulting in death)	- Puin	onany	In	ab	0-6-t	2012-			
DUE TO (ORFAS A CONSEQUENCE OF):									
Sequentially list conditions. To Caparture heat factor									
Sequentially list conditions, if any, lasding to immediate									
cause. Enter UNDERLYING CAUSE (Disease or injury									
that initiated events resulting in death) LAST									
	d								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS									
24a. Was AN AUTOPSY PROPINGS PROPING TO COMPLETION OF CAUSE OF REATOP STATES.									
						— 1 tes 2	□ NO	OF DEATH?	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN I									
25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)									
EXAMINER? HOSPITAL: UTHER:									
The National Property of Death 1									
1 Netural 5 Pending (Month, Day, Year) INJURY WORK?									
2 Sylable	2 Accident Investigation " 1 YES 2 NO								
4 Homicide 6 Could not be determined	building,	stc. (Specify)			-	City or Town, State)			
29s. CERTIFIER 1 CERTIFYING PHY	SICIAN: To the best of	my knowledge, de	oth occurred	at the time of	ats and place and due	to the cause(s) and mar	ner se state	4	
2 XMEDICAL EXAMIN	IER: On the basis of s							csuse(s) and manner as stated.	
296. SHINATURE AND TITLE OF CERTIFI	ER V	TI.			O.C.M		29d. DATE	SIGNED (Month, Day, Year) IE 25, 1995	
30. NAME AND ADDRESS OF PERSON Y	HO COMPLETED CALL	E OF DEATH (ITE	# 27) (Type. F	Print)					
Mus	Non		,	,	reet, B	altimore	Mar	ryland 21201	

32 REGISTRAR'S GHAPUPA

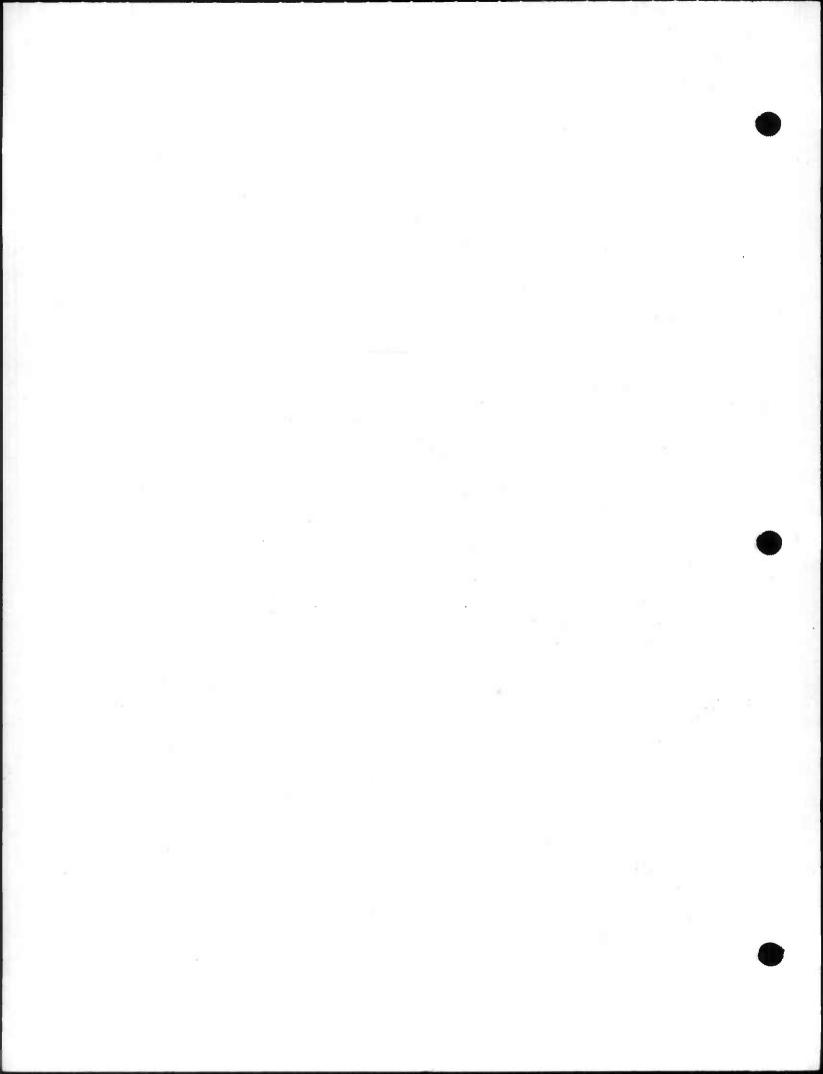
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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netfiled at once. DIVISION OF VITAL RECORDS, P.O. BOX 68769

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

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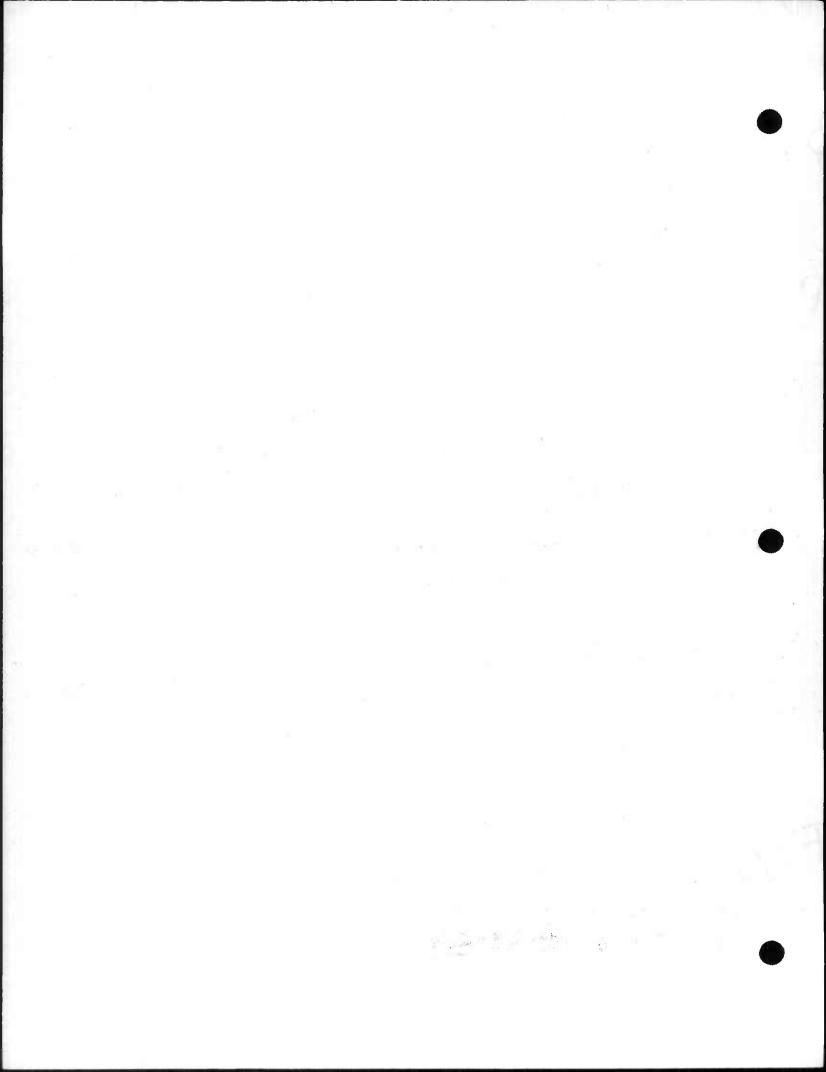


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FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH EUNICE M. KAHN-HOLLAND JULY 3, 1995 2:15 A. 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign MAR. II HOURS 415-50-1619 1 M 2 K F 58 YRS. TENNESSEE permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give atreet and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 3356 CRANBERRY S. LAUREL ANNE ARUNDEL RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND ANNE ARUNDEL LAUREL 1 TES 2 NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3356 CRANBERRY S. 20724 funeral director, page 5 should be detached for use as the burial-transit USA retained by the hospital or attending physician 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf were appetfy Cuban, Maxican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE - American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuban, Maxican, Puerto Ricar

1 YES 2 NO Specify: 1 Never Married 2 Married ВҰ 3XX Widowed 4 Divorced Specify: WHITE COMPLETED 15. DECEOENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) lege (1-4 or 5+) PURCHASING AGENT US GOVERNMENT 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle Maiden Surname) HENRY TILSON HOOD # WILLIE M. LARKIN BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code 2 STEVEN M. KAHN 3356 CRANBERRY S., LAUREL, MARYLAND 20724 death. Page 6 may be P 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State must BALTIMORE WASHINGTON CREM LAUREL, MARYLAND examiner 24- SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MD 20707 an and completely filled in by the to burial, cremation or completely medicai 23. PART I Enter the diseases, or complications that the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart fa IMMEDIATE CAUSE (Final **Onset and Death** the disease or condition RENA CHUCUM event, resulting in death) 2 years DUE TO (OR AS A CONSEQUENCE OF PUS (IRATORY FAT DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION FALURI Sequentially list conditions, If any, leading to immediate attending physician ntal Hygiene prior to death certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury other that initiated events DUE TO (OR AS A CONSEQUENCE OF): reaulting in death) LAST 0 been signed by the atte injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY requires that any 1 TES 2 NO OF DEATH? Shows 1 - YES 2 NO ICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN IN has be Dept. WE 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) this certificate h HOSPITAL: OTHER: 1 TES 2 NO OR ATTENDING PHYSICIAN: PHYSI 1 Inpetient 2 I ER/Outpetient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY marked, 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY After t 2 Accident 28e. PLACE OF INJURY — At home, farm, atreet, tactory, office building, etc. (Specify) 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 50 DIRECTOR: A hours after d item 28 is COMPLETED 8 Could not be 4 📋 Homicide determined Hem 29a. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. HOSPITAL FUNERAL I 900 TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

7/3/95 BE felle D45014 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARTIRE #420 LNROZ MO ISABELLA VAN DUSEN RA 7350 2 JUL 0 7 1995 32 REGISTRAR'S SIGNATURE



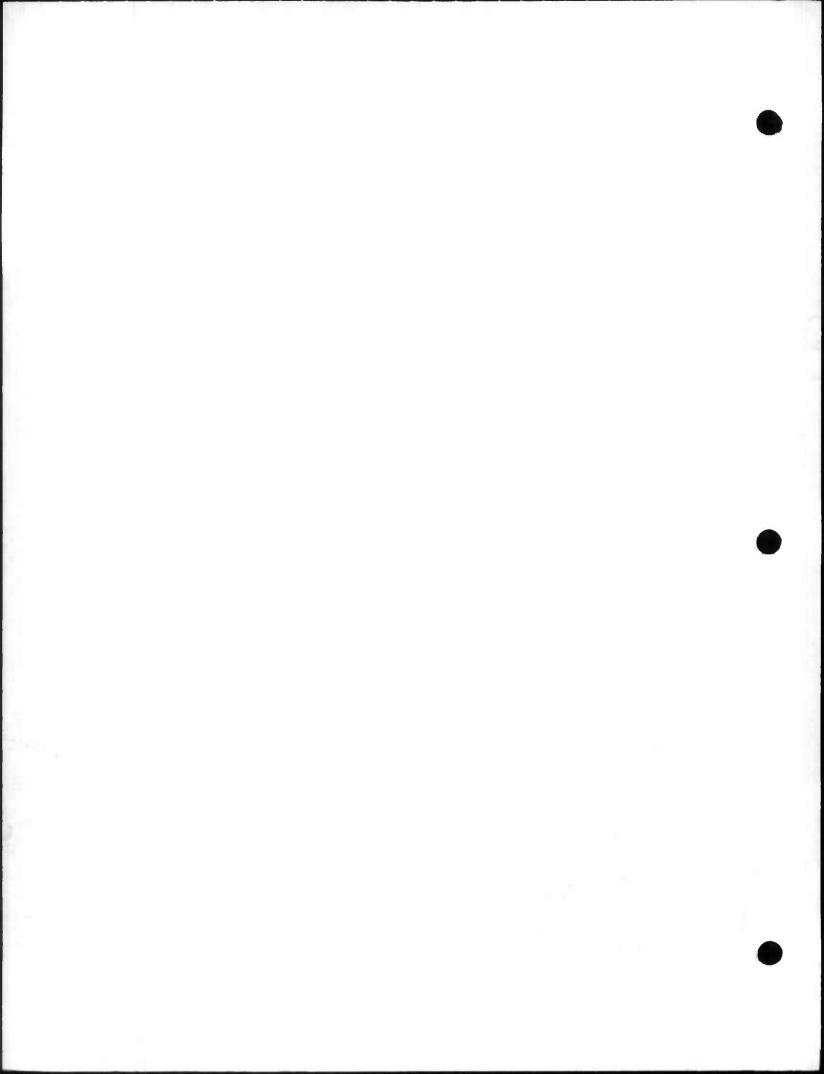
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the float death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	OF MARYLAND			HEALTH AND	ME	NTAL HYGIEN	E		
1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR							3. TIME OF DEATH			
		2211011								0218 M
	4. SOCIAL SECURITY NUMBER 5. SEX 221 10 3667 1 X M 2	5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 74 YRS, MONTHS				7.	Month, Day, Year)		Count	
	9s. FACILITY NAME (If not institution, give street and num		9b. CITY, TOW	N OR LOCATION OF	DEATN 9c. COUNTY OF DEATN				EATN	
DIRECTOR	Washington County Hos		Hage	Hagerstown Washingto					ton	
EC	10s. STATE 10b. COUNTY		10c. CITY, TOWN DR LOCATION Rosedale						10d, INSIDE CITY	
	Md. Baltimore									LIMITS? TYES 2 NO
FUNERAL	7913 32nd. Street								ZEN OF V	VHAT COUNTRY?
S	11. MARITAL STATUS 12. WAS DE	CEDENT EVER IN U.S.	ARMED				RIGIN? (Specify Yes			- American Indian,
BY F	1 Never Married 2 Merried IF YES,	S? 1 YES 2 GIVE WAR DR DATES	NO		specify Cuban, Max ES X ND Spe		serto Ricen, etc.)		Speci	k, Whits, etc.
	15. DECEDENT'S EDUCATION	W.W.2	25050011710	1					Whi	te
	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-			USUAL OCCUP. vork done during retired.)			16b. KIND OF BUS	INESS/IND	DUSTRY	
PL	12	4 07 5 +)	Prin	ter			Prin	ting		
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)				18. MOTNER'S NAME (First, Middle, Malden Surname)					
BE	Unknown	Lynch		_			nown			
2	190. INFORMANT'S NAME (Type/Frint) Robert W. Lynch		196. MAILING 7913	32nd.	street F	OSE	Number, City or Town	212	Gode)	
	20a. METHOD OF DISPOSITION	20b. PLAC	EANDDATEC	OF DISPOSITION		1				wn, State
	1 Burlet 2 Cremetton 3 Removal from Stats 4 Donetton 8 Other (Specify) Green Mount Cemetery, cremetory or other place) Baltimore, Md.								Md.	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Charles S. Zeiler & Son Inc.									
	6224 Eastern Ave. Balto., Md.									
	23. PART I. Enter the diseeses, or complication shock, or heart failure. List only or	ns thet ceused the one ceuse on each ili	deeth. Do n	ot enter the	node of dying, s	ich se	cerdiec or reapi	ratory srr	est,	Approximete interval Between
	iMMEDIATE CAUSE (Finel disesse or condition	A + 0		A		1	1 - 0	,		Onset and Death
	resulting in death) a	A CUTE CONS	EOUENCE OF	7:	Myse	د - و	ic, th	Wa C pi	3~	24 harri
N	Sequentially list conditions,	Severa (DUE TO (OR AS A CONS DUE TO (DR AS A CONS	1-0-1-	7 A-	my Dig	en	_			7
ATIO	if sny, leading to immediate ceuse. Enter UNDERLYING	DUE TO (OR AS A CONS	EQUENCE OF	7: \	0	J.	ander D	· sees	L) years
FIC	CAUSE (Disease or injury that initiated events	DUE TO (DR AS A CONS	EQUENCE OF	7: 241	h Le		zschemi	9		
CERTIFICATION	reaulting in death) LAST					9				
AL CI	PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS									WERE AUTOPSY FINDINGS
ICA	Dubeles Mellit		4 8	epule	4		PERFOR	MEO?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
PHYSICIAN: MEDICA							1 1 123 2	ND ND		DF DEATH?
ž	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? EXAMINER? CONTROL C									
НYS		1 Sinpetient 2 ER/Outpetient 3 DOA 4 Nursing Name 5 R								
ВУ Р	1 Natural 5 Pending (M	Ionth, Day, Year)		28b. TIME OF INJURY AT WORK? M 1 YES 2 NO			I. DEŞCRIBE NOW IN	JURY OCC	CUREO	
	3 Suicide 8 Could not be	28s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Soecify)					28t. LOCATION (Street and Number or Rural Route Number, City or Youn, State)			
E.	4 Nomicide datermined									
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: On the bar	beat of my knowledge, on the state of examination and/o	death occurre r investigation	d at the time, d	ts and place, and d	e time	e cause(s) and man , date and place, and	ner se atate	ed, e ceuse(s	and manner so stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE N	_				(Month, Day, Year)
TO BE	Kil 1 Dy In				D387			•	7/	3/15
F	30. NAME AND ADDRESS OF PERSON WHO COMPLETE	D CAUSE DF DEATH (IT	EM 27) (Type,	Print)	RE					e en a 217.15
	31. DATE FILEO (Month, Day, Year) 32. RE	GISTRAR'S SIGNATURE		-2-60	1.6	ו ייינ	100	Hegen	14.20	~ MO 21742
	JUI 07 1995 Juli St	welson Randal	l							
JUI 07 1995 Juli Shirdson Randall										



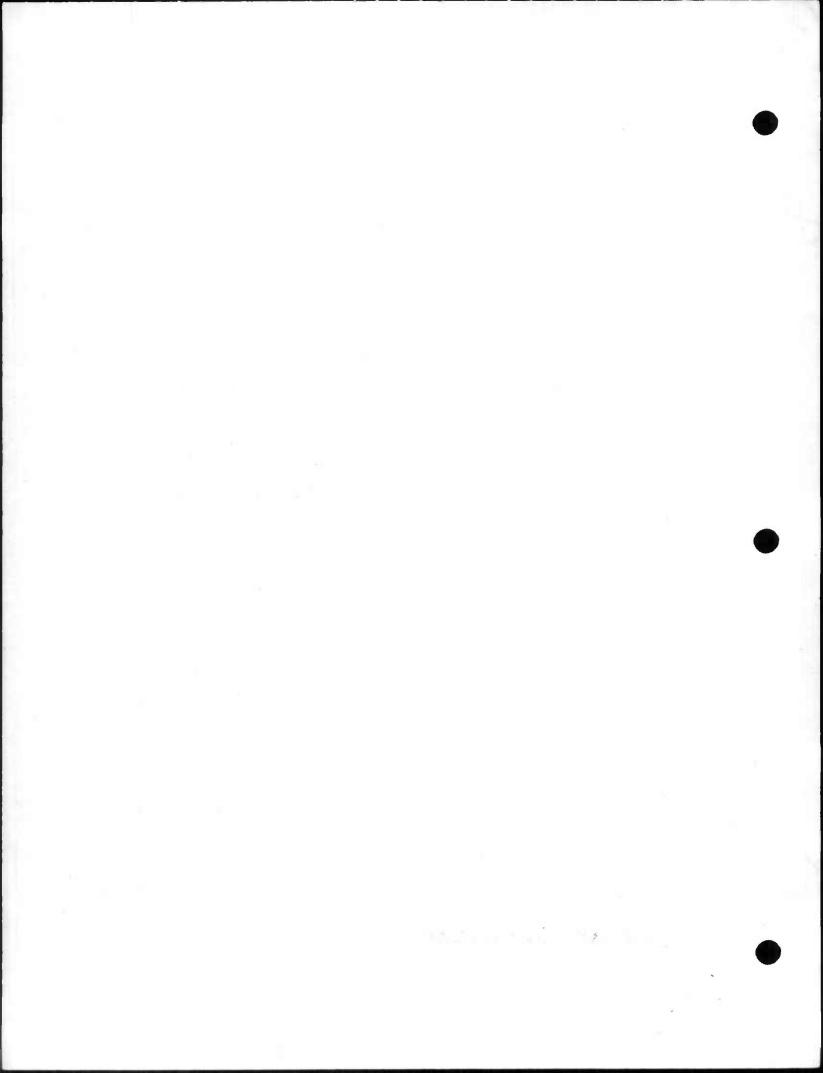
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate he executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be find with the State Ober, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPURIARY: If them 26 13 marked, of them 23 shows any injury, of other traumanc event, the medical examiner must be noutlied at once.

	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
TRAR	CERTIFICATE OF DEATH	REG. NO.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Leet) Joseph Mark	Laker		2. DATE OF DEATH M9NTH1y 04,199	3. TIME OF DEATH 9:30 P M			
	215-82-3563 1∑ м ₂ □ ғ		F UNDER 1 YEAR IF UNDER 24 HRS. ONTHE DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) June 6, 1961	8. BIRTHPLACE (Stote or Foreign Country) Maryland			
TOR	99. FACILITY NAME (If not institution, give street end number) Maryland General Hospital RESIDENCE OF DECEDENT	9	Baltimore		TY OF DEATH /A			
DIRECTOR	Maryland Baltimore	10c. CITY, 1	Baltimore		10d. INSIDE CITY LIMITS? 1 YES 2 A NO			
FUNERAL	9223 Seven Courts Drive		101. ZIP CODE 21236	EN OF WHAT COUNTRY?				
BY FUN	11. MARITAL STATUS 1 X Never Merried 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER FORCES? 1 YES, GIVE WAR OF	ER IN U.S. ARMED ES 2 X NO R DATES		NIC ORIGIN? (Specify Yes or No—	14. RACE — American Indien, Black, White, etc. Specify: White			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16b. KIND OF BUSINESS/IND	USTRY					
N N	12th grade 17. FATHER'S NAME (First, Middle, Last)	Plumber		Plumbing Con	ntractors			
	Norman Francis Laker, Sr.			ame (First, Middle, Meiden Surname) abeth Giese				
BE	19e. INFORMANT'S NAME (Type/Print)	19b. MAILING AC		Route Number, City or Town, State, Zip	Code)			
2	Elizabeth Laker (mother)			ive, Baltimore,				
		20b. PLACE AND DATE OF Commetery, cremetory or other St. Joseph	place) Cemetery	DATE 20c. LOCATION — C	My or Town, State			
	21. SIGNATURE OF FUNERAL SÉRVICE LICENSEE			neral Homes, Inc				
	117 11	-		Rd., Baltimore,				
	23. PART I. Enter the diseases, or complications that ceu shock, or heart fallure. List only one cause of	sed the death. Do not	enter the mode of dying, au	ch as cerdlec or reepiratory arre				
	IMMEDIATE CAUSE (Final disease or condition							
	DUE TO (OR AS A CONSEQUENCE OF):							
N	Sequentially list conditions, AIDS							
ATIO	If any, leading to immediate cause, Enter UNDERLYING	S A CONSEQUENCE OF):						
CERTIFICATION	CAUSE (Disease or Injury that Initiated evants resulting in death) LAST	S A CONSEQUENCE OF):						
	PART II. Other algorificant conditions contributing to deat	h but not resulting in t	he underlying cause given in	Part I. 24a, WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS			
CAL	Mycobacterium Avium-			PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
MEDIC	Pneumocystis Carini:			1 □ YES 2 MÃ NO	OF DEATH?			
N.	DID TOBACCO USE CONTRIBUTE TO CAUSE	OF DEATH YES	□ NO □ UNCERTAI		1 1 163 2 1 10			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	28. PLACE OF DEATH (Check only one) THER:					
ΙS	1 YES 2 X 10 1 Morpetient 2 ER/O	Putpetient 3 DOA 4	□ Nursing Home 5 □ Residence					
	1 Netural 5 Pending (Month, Day, Yea	Y 26b. TIME O		26d. DESCRIBE HOW INJURY OCC	URED			
ЭВУ	2 Accident Investigation 3 Suictde 6 Could not be	JRY — At home, farm, stre		26t. LOCATION (Street and Number of	or Rural Route Number			
TED	4 Homicide determined building, etc. (S	Specify)		City or Town, State)				
PE	29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my kn	owledge, death occurred a	t the time, date end place, end du	to the cause(e) and manner as state	d.			
COMPLET	One) 2 MEDICAL EXAMINER: On the besie of exemina	ition end/or investigation, i	n my opinion, death occured at the	time, date end piece, end due to the	Couse(e) end manner ee stated.			
BE	296. SIGNATURE AND TITLE OF CERTIFIER WAS	IM FAKH	AM, M. D 29c. LICENSE NU	MBER 29d. DATE	SIGNED (Month, Day, Year)			
10	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF WAS I'M FAKhar, H.D. C	o Marylai	id General H	ospital				
31. DATE FILED (Month, Day, Year) 32. REGISTEAR'S SIGNATURE JUL 0 7 1995 Falsa d'avaluar hardall								

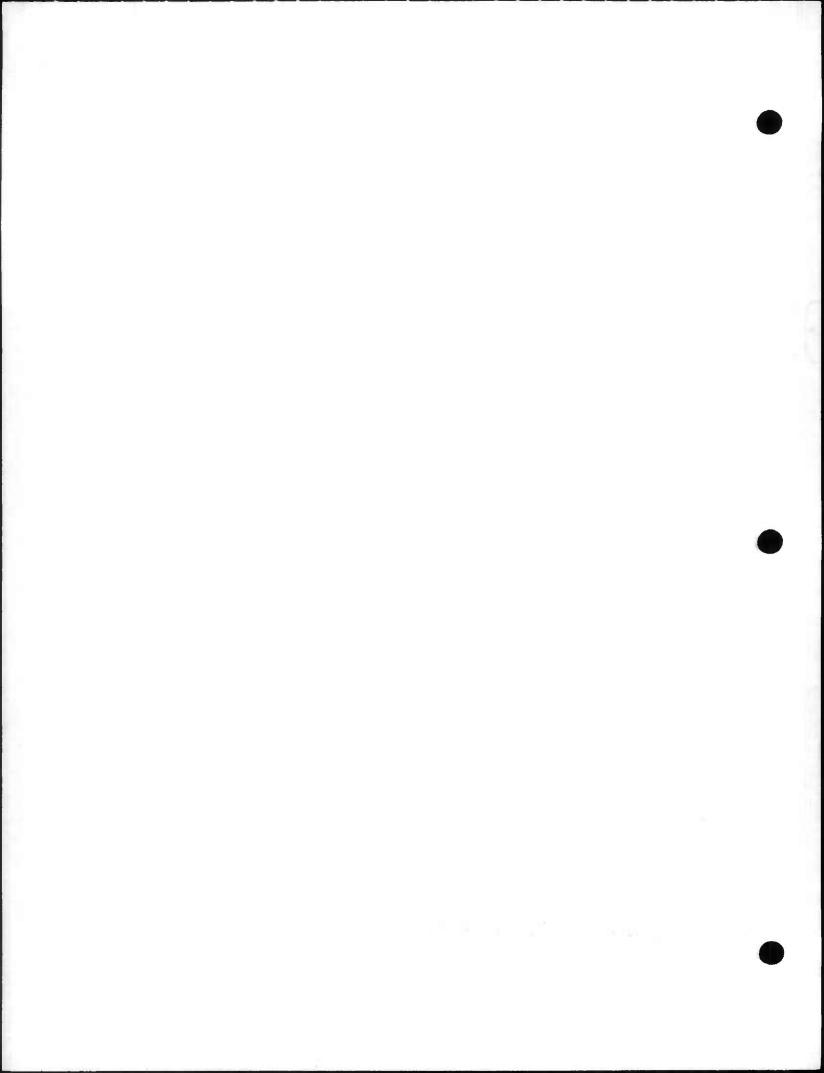
		1 - FOR STATE REGISTRAR	STATE OF I	WARYLAND C	DEPAR	RTMENT	OF H	IEALTH DE A	AND	MENTA	HYGIEN REG. NO.		- Cours	0000
		1. DECEDENT'S NAME (First, Middle, Lest) WILLIAM	F	١.				LAM			OF DEATH		9 ^{VEAR}	TIME OF DEATH
D		4. SOCIAL SECURITY NUMBER 217-66-3910	5. SEX 1 (XM 2 () F	6. AGE (In yrs. In	st birthday) YRS.	IF UNDER	1 YEAR DAYS	HOURS	R 24 HRS.	7 DATE	OF BIRTH	T	a. BIRTHP	yland
2, 3 shoul	стоя	98. FACILITY NAME (If not institution, give st						OR LOCATI				9c. COUN	N/A	
. Pages 1,	DIRECT	10a. STATE 10b. COUNTY	I/A			Y, TOWN O		TION		-				Od. INSIDE CITY LIMITS? YES: 2 NO
UZU physician. burial-transit permit. Pages 1, 2, 3 should	FUNERAL	100. STREET AND NUMBER 1144 Cleveland S	it.					ZIP COD	£)	-	10g. CITt2		AT COUNTRY?
a a a	B≺	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2 V		1	yes, sp		n, Mexica	n, Puerto F	? (Specify Yes	or No—	14 BACE -	- American Indian, White, atc.
oital or attend	PLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5	+) (G	Bive kind of a Do NOT u	,	CUPATIO	ON st of working	ng	16b.	KIND OF BUS			
2 2 E	E COMPL	17. FATHER'S NAME (First, Middle, Last) Wilson A. Lam,	N/A Sr	U.	ie Ma	Ker_					Ste Mddle, Maiden pleski	,	ompan	У
viAn retained 5 should	TO BE	19a. INFORMANT'S NAME (Type/Print) Wilson A. Lam, J		19	6707	ADDRESS	(Street a	nd Number	or Rural I	Route Numb	or, City or Town	n, State, Zip	Code) Md.	21236
e 6 may be rector, page t		20s. METHOD OF DISPOSITION 1 Burlet 2 Cremation 3 Remote 4 Donation 5 Other (Specify)		20b. PLACE cemetery, cre	AND DATE	OF DISPOSI	TION /Na	me of		7/ ₁	20c. LO	CATION - C	City or Town	
DALLIMOR Ours after death. Page 6 m of in by the funeral director, or removal. medical examiner must		21. SIGNATURE OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227												
executed within 24 if and completely filled burial, cremation, natic event, the	CATION	23. PART I. Enter the diseases or cahock, or heart leture. I IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditiona, if any, leading to immediate	DUE TO	TOR AS A CONSE	OUENCE O	F):	tha mo	de of dyl	ing, suc	h aa card	lac or reaple	retory arre	eat,	Approximate Interval Between Onset and Daath
th certificat ending phy I Hygiene p	CERTIFICA	CAUSE (Disease or Injury that Initiated events reaulting in deeth) LAST d												
w requires that the death is been signed by the atter pt. of Health and Mental 3 shows any injury, or	EDICAL	PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO COMPLETION OF CAUSE OF DEATH?									WAILABLE PRIOR TO DMPLETION OF CAUSE			
has b Dept.	IAN: M	DID TOBACCO USE CONTR	RIBUTE TO CA			S D N		UNC	ERTAIN	۷ 🗆			1	YES 2 NO
PHYSICIAN: The this certificate he with the State Driked, or item	HYSICIAN:	EXAMINER? 1 XYES 2 NO 27. MANNER OF DEATH	HOSPITAL:	ER/Outpatient 3		OTHER 4 - Nursi	:		sidence	6 Other				
P. Strike	BY PH	1 Netural 5 Pending 2 Accident Investigation 3 Suitable Could not be	6 28e. PLACE O	INJURY Found by, Year) Found 27-95 FINJURY — At ho	102	JURY JUM	1 🗌 Y	ES 2	∂ NO	Sus	TION (Street a	has	ged	self.
OR ATTEN IRECTOR: ours after	LETED	4 Homicide determined	building	es, den	ce					((66	Was	hingl	v~ (3 Walling
TO THE HOSPITAL OF TO THE FUNERAL DE FIED WITHIN 72 PARIMPORTANT: IT IN	COMPLET	(Check only one) 2 MEDICAL EXAMINES												nd manner as stated.
TO THE P TO THE P be filed v	TO BE	29b. SIGNATURE AND THTLE OF CERTIFIER	Ex.	LL					C . M				SIONED (M	8, 1995
7		30. NAME AND ADDRESS OF PERSON WHO	OW Or				ree	et,	Bal	timo	re, l	Mary.	land	21201
		JUL 0 7 1995	32 REGISTRA	R'S SIGNATURE										



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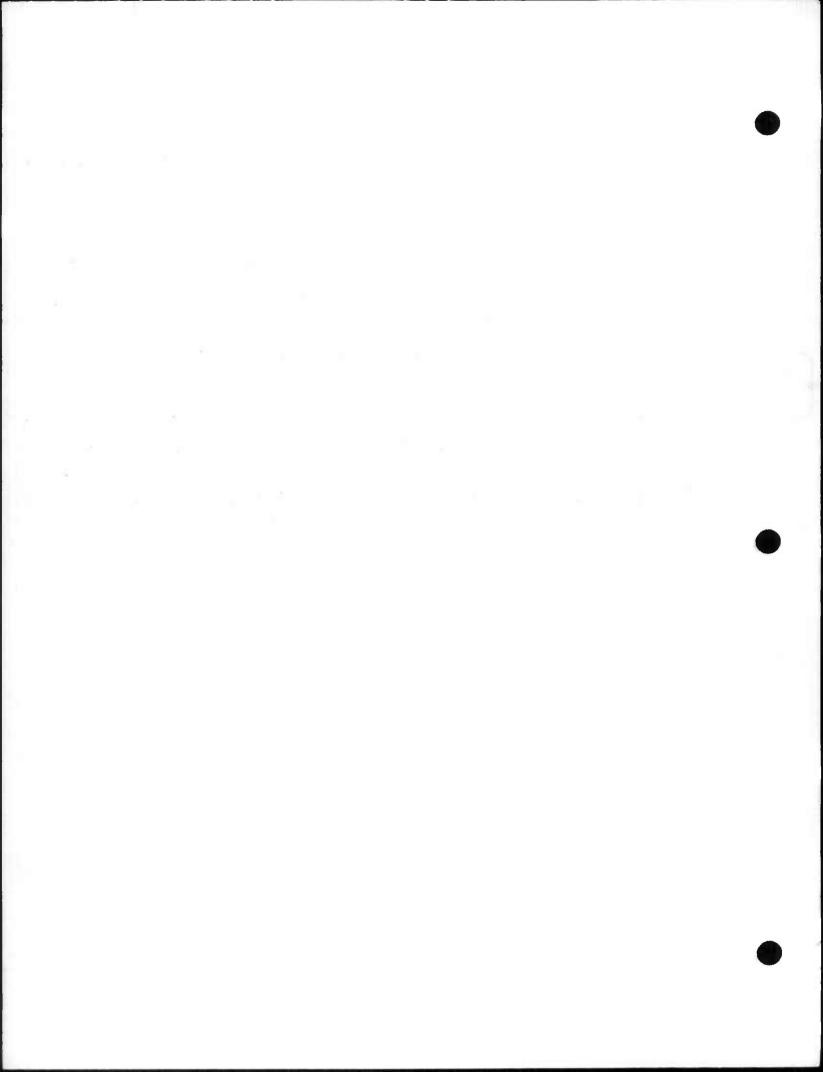
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	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR CERTIF	TMENT OF I	HEALTH AND M					
	1. DECEDENT'S NAME (First, Middle, Last)	6			T	2. DATE OF DEATN		3. TIME OF DEATH	_	
	ROBERT		DREN	CE		TULY 3) м	
	4. SOCIAL SECURITY NUMBER 216-68-5644	1 1 M 2 D F 3	yrs, last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	MAY 04/	-	**Suprinplace (State or Foreign Country) **Maryland** **Country Of DEATH N/A 10d. INSIDE CITY LIMITS? 1		
OR	90. FACILITY NAME (If not institution, give st Bayview Medical (ARTMENT OF HEALTH AND MENTAL HYGIENE IFICATE OF DEATH Control Control						
DIRECTOR	RESIDENCE OF DECEDENT 10n. STATE 10b. COUNTY	,	10c. CIT	Y, TOWN OR LOCA	TION			104 INSIDE CITY	_	
	Maryland N/A				Baltimo	re City	Las orres	1 X YES 2 NO		
ERA	317 E. North Ave	Apt. 107			CHEST THE					
Y FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DAT	2- NO	It yes, sp	CENDENT OF NISPANIC	ORIGIN? (Specify Yes		I. RACE — American Indien, Black, White, etc.		
D BY	3 Widowed 4 Divorced							Black		
ETE	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give kind of s	work done during me	ON ost of working			TRY		
COMPL	17. FATHER'S NAME (First, Middle, Last)		Laborer		18. MOTNER'S NAM				_	
i w	John Lawren	nce						1		
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILINO	ADDRESS (Street						
F	Latanya Lawrence									
	20e. METHOD OF DISPOSITION 1 Burlel 2 Cremetton 3 Remo	oval from State 20b.P	LACE AND DATE (ery, crematory or or LO CIEM	of disposition (Nather place)	ame of [nc. 07/06	0ATE 20c. LO				
	1. SIGN TUBE OF FUNERAL SERVICE LICENSED 2	enseDawn F. McD	onald	22. NAME A	NO AODRESS OF FACI	LITY				
aye	Damet Met	Donald		299 Fr	cederick F	ety of Mar Road Balti	yLand,	, Inc. MD 21228		
	23. PART I. Enter the diseesea, or c shock, or heart failure.	omplications that caused t	the deeth. Do r	not enter the mo	ode of dying, auch	as cerdiac or respi	ratory arres	t, Approximata	Between	
	IMMEDIATE CAUSE (Final disease or condition	A					1	Onset and Dea		
	resulting in death)	DUE TO (OFF AS A C	CONSEQUENCE OF	n va cone	Cificent	y syne	myn	egis		
RTIFICATION	Sequentielly list conditions, if any, leading to immediate	DUE TO (OR AS A C	CONSEQUENCE OF	F):		0				
-ICA	cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A C	ONSEQUENCE OF							
CERTIF	that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): d									
1 . 1	PART II. Other significant conditions	contributing to death but	not reaulting i	in the underlyin	g ceuse given in P				S	
MEDICAL	dismino	Ard MAI!	ntxn;				11	COMPLETION OF CAUSE		
	DID TOPACCO LICE CONTE		opati	44	1	_		1 TES 2 NO		
SICIAN: ME	DID TOBACCO USE CONTR				UNCERTAIN	Ш			4	
SICI	EXAMINER?	HOSPITAL:		OTHER:	ne 6 Paeldence 6	Other (Cossibil			\dashv	
27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Dey, Year) 28b. TIME OF 18JURY AT WORK? 28d. INJURY AT WORK?							NJURY OCCUP	RED		
	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, etc. (Specify	- At home, ferm, a				and Number or	Rurel Route Number,	\exists	
LETED	20e CERTIFIER V								Rindings Ar To Cause	
COMPL	(Check only	CIAN: To the best of my knowled R: On the beels of examination s						euse(a) and menner as stated.		
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	M.O.			294 LICENSE NUMB	ER 9	29d. DATE S	IGNED (Month, Day, Year)		
2	30. NAME AND A GORESS OF PERSON WHO	COMPLETEO CAUSE OF OEAT	H (ITEM 27) (Type,	Aver	use Pn	Himano	m	21224		
	31. DATE FILED (Month, Day, You'c)	LL Missian Kard	ril.	1100	IVIC 14	CITICOLO		MILL	\dashv	

30. NAME AND AGORESS OF PERS LACEN LIDER 31. DATE FILED (Month, Day 1995)



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4. SOCIAL SECURITY HUMBER 5. SEX 1 W M 2 F 8. AGE (In yrs. lest birthdey) F UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE MONTHS DAYS HOURS MIN. MONTHS MIN.	OF DEATH DAY YEAR 3. TIME OF DEATH 1945 M OF BIRTH 1, Dey, (Stell) 1945 8. BIRTHPLACE (Stelle or Foreign Country)
9a. FACILITY NAME (If not institution, give street and number) 9b. CITY TOWN OR LOCATION OF DEATH	OP BIRTH 8. BIRTHPLACE (State or Foreign County)
9a. FACILITY NAME (If not institution, give street and number) 9b. CITY TOWN OR LOCATION OF DEATH	8. BIRTHPLACE (State or Foreign Country)
9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH	
	9c. COUNTY OF DEATH
St. Agnes Hospital Baltimore RESIDENCE OF DECEDENT 109. STATE 100. CITY, TOWN OR LOCATION BALTIMORE RESIDENCE OF DECEDENT 100. CITY, TOWN OR LOCATION BALTIMORE	NA
10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
	1 PYES 2 NO
5 EIO KOBERTS AVENUE 121228	10g. CITIZEN OF WHAT COUNTRY?
2 4 2 1 1 1 January & C. Marrior	17 (Specify Yes or No— 14. RACE — American Indian, Black, Whita, etc.
Divorced 4 □ Divorced 1 □ Divo	specity: Black
15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15b. DECEDENT'S EDUCATION (Give kind of work done during most of working life. Do NOT use retired.)	KIND OF BUSINESS/INDUSTRY
Maintenance Fra	Private.
NO TO THE PROPERTY NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Last)	Middle, Meiden Surname)
TARE TO THE STATE OF THE STATE	lalatorro
2 to EIF MANITA MASSINS III) KALOGIS AVA	Balta, Md. 21228
206_METHOD OF DISPOSITION DATE OF DISPOSITION (Nam) of DAT	E/ 29c. LOCATION City or Town, State
20 NAME AND ADDRESS OF FINERAL SERVICE A L'ENSEE	9stLaurel, Ma.
Joseph Liku	155 Funeral Home
23. PART/ Enter the diseases, or complications that caused the death. Do not enter the mode of dving, such as carr	flac or reapiratory arreat, Approximata
DE DE MANAGEMENT CONTRACTOR CONTR	interval Between Onset and Death
disease or condition resulting in desth) The property of the control of the cont	2 Westes
P & B & B & B & B & B & B & B & B & B &	rotif 3 months
8 " O E DUE TO (OR AS A CONSEQUENCE OF):	
CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE DF):	-
r = 2 - 1 m	
N 0 0 0 1 1 1	24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS
	1 U YES 2 NO COMPLETION OF CAUSE OF DEATH?
	1 Ures 2 No
EXAMINER? Comparison Compa	r (Specify)
D E 2	CRIBE HDW INJURY OCCURED
Accident Investigation See PLACE DF INJURY — At home, term, street, factory, office building, etc. (Specify) 26a. PLACE DF INJURY — At home, term, street, factory, office building, etc. (Specify) City	ATIDN (Street and Number or Rural Route Number,
D NIGHT STATE OF STAT	or Yown, State)
PAR = N (Check only one)	
# # B B W	29d. DATE SIGNED (MO)th, Day, Year)
888 0	2 1/3/73
D-15 40 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo Pylnt) ATIA HAMAN, M.O., 7/6 MAIDEN CHOICE L	ANE BALT MD 44

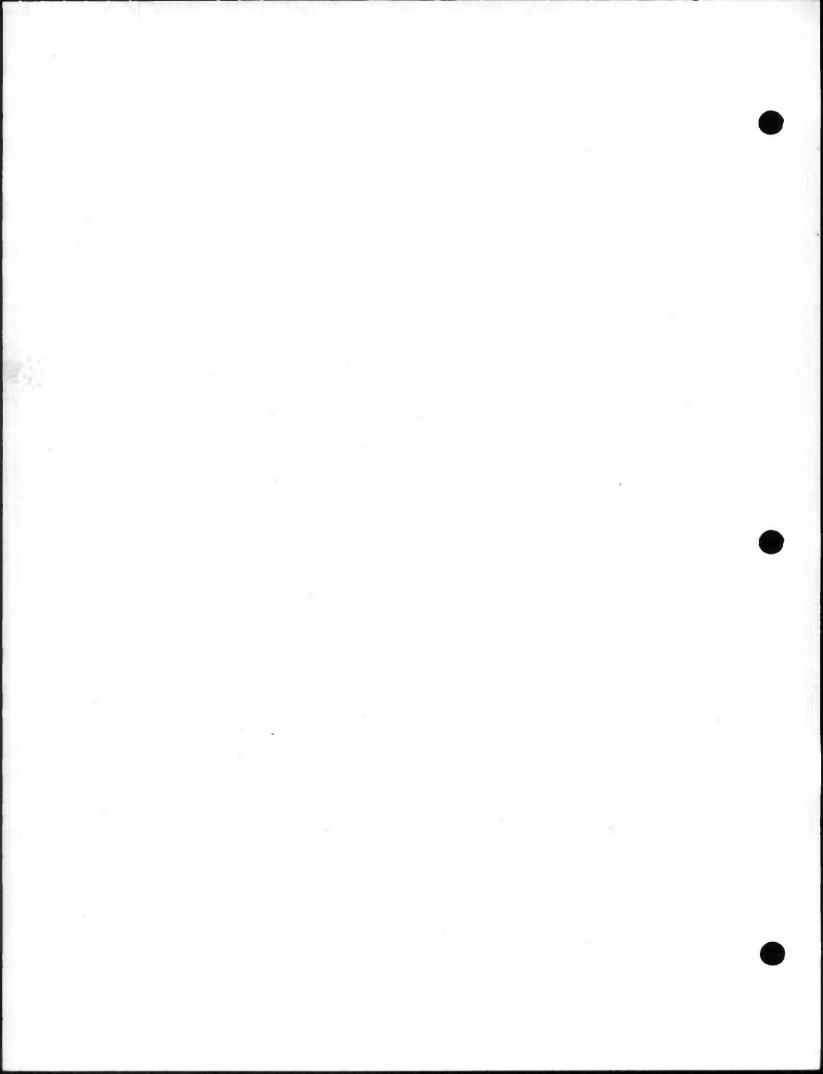


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

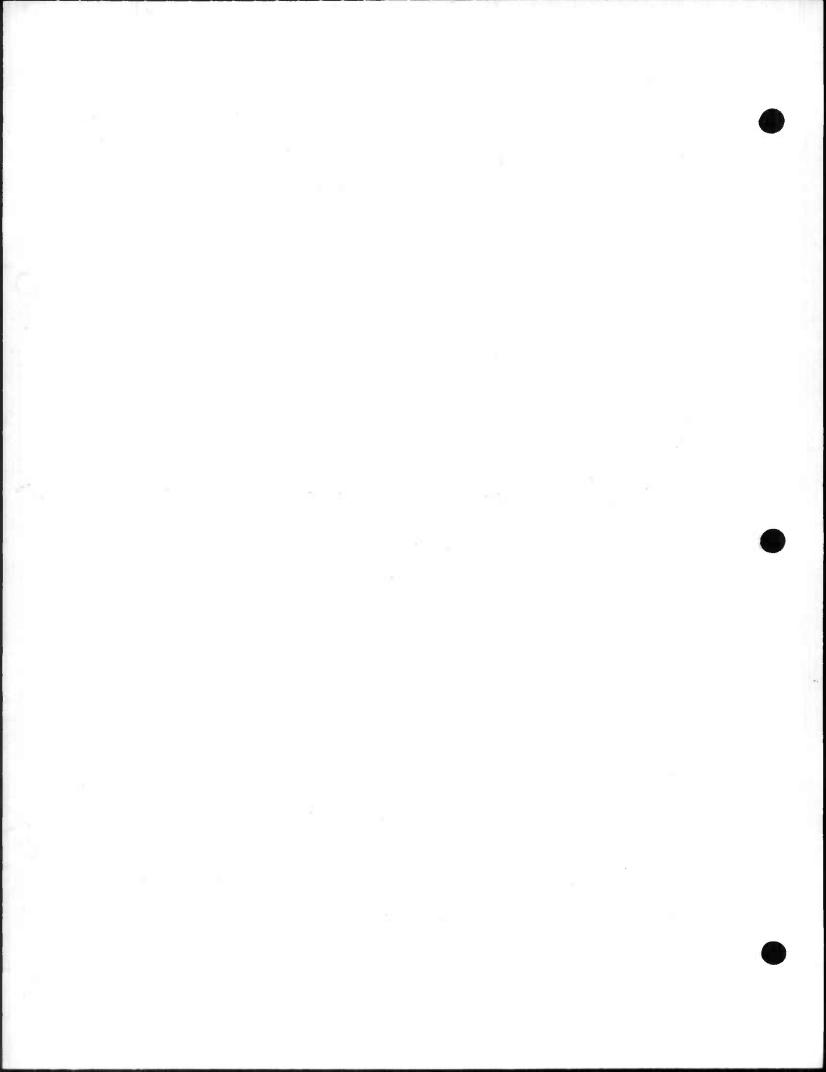
	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last) GLENN LI	ONEL MATTH	EWS		2. DATE OF DEATH MONTH DA	995	3. TIME OF DEATH 4:30 P M	
	010 50 0055		yrs. last birthday) IF L	THE DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) SEPT. 21, 1	8. B	HATHPLACE (State or Foreign ountry) BALTIMORE, MD	
TOR	90. FACILITY NAME (If not institution, give etre- 5619 CLE RESIDENCE OF DECEDENT		OAD 9b.	CITY, TOWN OR LOCATION OF D BALTIMO	EATH	9c. COUNTY C		
DIRECTOR	MARYLAND 106. COUNTY	N/a	10c. CITY, TO	WN OR LOCATION BALTIMO	RE		10d, INSIDE CITY V LIMITS? 1 Sec. 2 No	
FUNERAL	100. STREET AND NUMBER 5619 CLE	ARSPRING RO)AD	101. ZIP CODE 212	12	UNIT	OF WHAT COUNTRY?	
BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, OIVE WAR OR DAT	2 X NO	13. WAS DECENDENT OF HISPA If yes, specify Cuben, Mexico 1 YES 2 NO Specifi	in, Puerto Rican, etc.)		RACE — American Indian, Black, White, etc. Specify: BLACK	
COMPLETED	15. DECEDENT'S EDUCATION only highest grade continued to the secondary (0-12) 12 TH	College (1-4 or 6+)	Ilfe. Do NOT use retir	fone during most of working	166. KIND OF BUS	GOMERY	WARDS CO.	
BE COM	17. FATHER'S NAME (First, Middle, Last) EDGAR D. M	IATTHEWS			ME (First, Middle, Malden			
TO B		HEWS	196. MAILING ADD 5619	RESS (Street and Number of Rural CLEARSPRING	ROAD, BA	n, Stelle, Zip Code LTIMOR	Ë, MARL.21212	
	20e. METHOD OF DISPOSITION A & Burlel 2 Cremation 3 Remove 4 Donation 8 Other (Specify)	ol from State come!	PLACE AND DATE OF DIS	RY CEMETERY	7-8 B	CATION — CITY OF		
	21. SIONATURE OF FUNERAL SERVICE LICENS BUMAN D	Johnson		WM. C. MARCH		E. NOF	RTH AVENUE	
CERTIFICATION	23. PART I. Enter the diseases, or conshock, or heart failure. Let improve the condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	RC1P, van	ONSEQUENCE OF):	SI HEE	th as cardisc or respi	ratory arrest,	Approximate Interval Batween Onset and Death	
MEDICAL C	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO							
CIAN:	DID TOBACCO USE CONTRII		. PLACE OF DEATH (C	heck only one)	N 🗆		70.	
Y PHYSICIAN:	1 YES 2 NO 1 27. MANNER OF DEATH Natural 5 Pending	Inpatient 2 ER/Outpet 28e. DATE OF INJURY (Month, Day, Year)		Nursing Home 5 Residence 28c. INJURY AT WORK? M 1 YES 2 NO	6 Other (Specify) 28d. DESCRIBE HOW IF	NJURY OCCURE	D	
TED BY	Paccident Investigation						ural Route Number,	
COMPLET				the time, date end place, end due my opinion, death occured at the			use(a) and manner se stated.	
BE	29b. SIGNATURE AND TITLE OF CENTIFIER	19 MO	*	29c. LICENSE NU	MBER Y	29d. DATE SIG	(Month, Day, Year)	
10	SDW WA TO A STREET OF PERSON WHO O	Union	menoeir	1 11 . 1 /	Baltin	one,	may low	
	JUL 07 1995 Jul	32 REGISTRAR'S CONST DRUCLER CONST	all.					



DIVISION OF VITAL RECORDS, P.O. BOX 68760

0700 01717 011011 (1110)	PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hydiene prior to burial, cremation, or removal.	te medical examiner must be notified at once.
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF	HEALTH AND	MENTAL HYGIEN REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATN		3. TIME OF DEATH	
	REGINA GRA	GRACE MUHL				TITLY 4		830 PM	
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In yrs. last birthday) IF L				7. DATE OF BIRTH	8. BIR	TNPLACE (State or Foreign	
	215-12-9826	¹□ M 2 🟋 71	YRS.	MONTHS DAY	HOURS MIN.	(Month, Day, Year) 09-23-192		RYLAND	
	9a. FACILITY NAME (If not institution, give a	street and number)		9b. CITY, TOW	OR LOCATION OF		9c. COUNTY OF		
DIRECTOR	96 CARNIVAL DRIV	E		IAT	EYTOWN		CAR	ROLL	
ក្ខ	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT	Y	10c CIT	Y. TOWN OR LO	ATION				
E .	MARYLAND CAR	ROLL	100. 011					10d, INSIDE CITY LIMITS? 1 YES 25 NO	
	10e. STREET AND NUMBER	KOLL		TANEY	IOWN IOF. ZIP CODE		10g, CITIZEN OF		
ER/	96 CARNIVAL DRIVE				2178	3 7		S.A.	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER I		13. WAS 0	ECENDENT OF NISP	ANIC ORIGIN? (Specify Yee		CE — American Indian,	
	1 Never Merried 2 Merried	FORCES? 1 YES		If yes,	specify Cuban, Mexic ES 2 NO Spec	cen, Puerto Rican, etc.)	810	ack, White, etc.	
) Вү	3 Widowed 4 Divorced							WHITE	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16e. DECEDENT'S (Give kind of	work done during	TION nost of working	16b. KIND OF BUS	INESS/INDUSTRY		
LE	Elementary/Secondary (0-12)	College (1-4 or 5+)	iile. Do NOT u						
ME	17. FATNER'S NAME (First, Middle, Last)	N/A	HOMEMAI	KER			HOME		
	CHRISTOPHER	REICHE	Э т		BLANC	IAME (First, Middle, Malden :		RMER	
BE	19e. INFORMANT'S NAME (Type/Print)	TUDIONE		ADDRESS /Com		I Route Number, City or Town		UIER	
2	RAYMOND V. MUHL, S	CD.						01505	
	20e. METHOD OF DISPOSITION	201	PLACE AND DATE			ANEYTOWN, M	ARYLAND CATION — City or	21787	
	Burial 2 Cremation 3 Rem	oval from State cen	netary, crematory or o	ther placa)		1995 BALT			
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	JODON PAI		AND ADDRESS OF F	ACH ITY			
	190 24	2//		1, 00	30110 1100			RAL HOME,	
	23. PART I. Enter the diseases, or capacitations	complications that cause	d the death De	1 SE	JOND AVER	NUE, S.W.,GI	TEN BURN	ME,MD. 21061	
	anock, or neart randre.	List only one cause on e	ach line.	ot enter the r	lode of dying, su	ch ss cardiac or respi	ratory arreat,	Approximate Interval Between	
	IMMEDIATE CAUSE (Finel disease or condition							Onset and Dasth	
	resulting in dasth) s. Yeurvicolar Hvyyumia							SMIN	
-	Sequentially list conditions. Ventvicular Arrythmia Sequentially list conditions. Sequentially list conditions.								
<u>ē</u>	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSCOUENCE OF):								
3	cause. Enter UNDERLYING	c							
	CAUSE (Disesse or Injury that initiated events								
CERTIFICATION	resulting in death) LAST								
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS								
CAL		e death b	or not resulting	in the underly	ng cause given ii	PERFORI		No. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
MEDIC						1 🗆 YES 2	NO	OF DEATH?	
Σ	DID TOBACCO USE CONTI	DIRLITE TO CALISE O	E DEATH VE	S D NO	T UNICEDTA			1 TYES 2 NO	
A A	25. WAS CASE REFERRED DO MEDICAL		26. PLACE OF DEAT						
	EXAMINER?	HOSPITAL:		OTHER:		6 Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIM	E OF 28c. I	JURY AT	28d. DEŞCRIBE HOW IN	JURY OCCURED		
BYP	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ		YES 2 NO				
ED B	3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Spec	— At home, ferm, s	treet, factory, of	lce	28f. LOCATION (Street ar	nd Number or Rura	l Route Number,	
	4 Homicide determined	building, etc. (Spec	ary)			City or Town, State)			
MPLE	29a, CERTIFIER (Check only	CIAN: To the best of my know	ledge, death occurre	d at the time, di	te end place, and du	e to the cause(e) and many	ner ee steted		
N N		R: On the beele of examination						(a) and manner ea stated.	
2	ON STONATURE AND TITLE OF CERTIFIER				29c_LICENSE NU				
2	()ouch	MND			D32	7296	DATE SIGNE	(Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DE	ATN (ITEM 27) (Type,	Print)	1 /	1210	1/6	110	
	R. Ricketts	MD We	Stmine	yes !	MD :	2115 >			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE	. , ,					
911	IIII 0 71995 July	Druder Rach	.4						



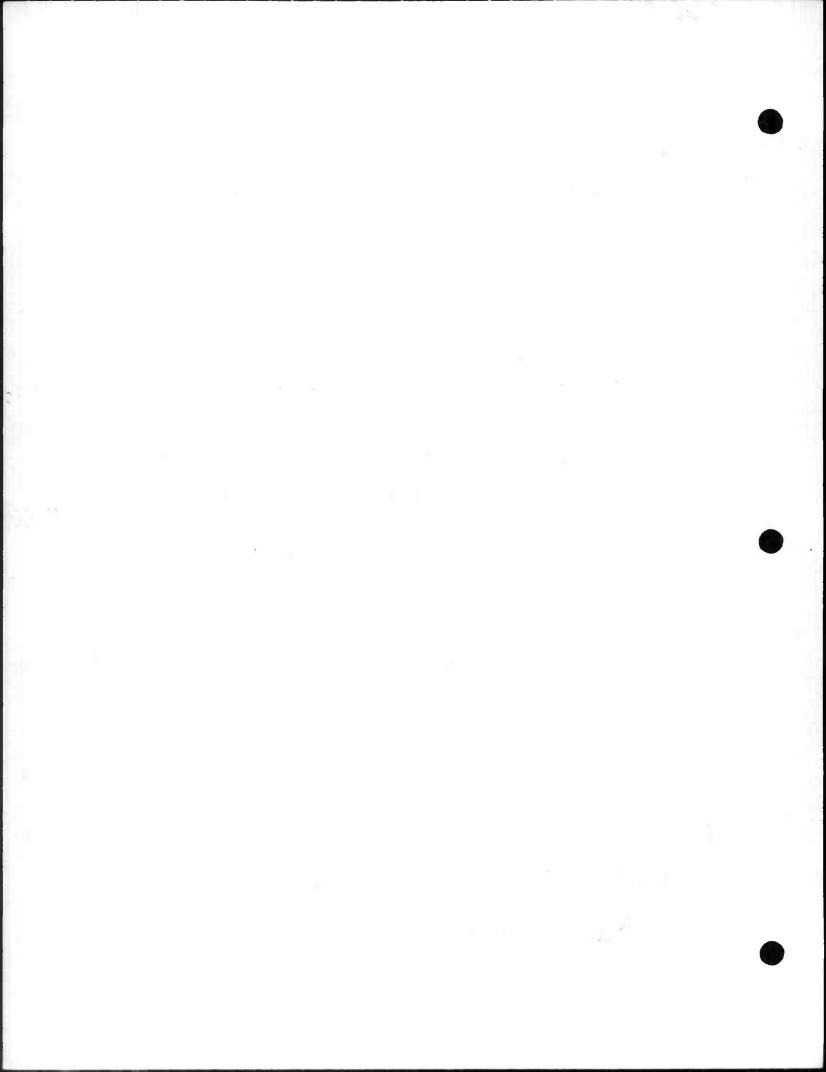
SOX 68760 BALTIMORE, MARYLAND 21215-0020 le be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death, certificate be executed within 24 hours after death. Page 6 may be retain TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be supposed the supposed by the standard process.

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR							DEATH			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF	DEATH		3.	TIME OF DEATH
	SAMUEL		MC C	LINTO	NT.		MONTH	DAY A		EAR	0
	4. SOCIAL SECURITY NUMBER	5. SEX		s. last birthday)	IF UNDER 1 YE	AR IF UNDER 24 HRS.	7. DATE OF	$\overline{}$	199		8 A
	248 22 0424				MONTHS DA		(Month, E			Country)	ACE (State or Foreig
	248-22-0424	X M 2 F	75	YRS.			DEC.	26.	1919	CAF	ROLINA
	9a. FACILITY NAME (If not institution, give :				9b. CITY, TO	VN OR LOCATION OF I	DEATH		9c. COUNTY		
СТОВ	HARFORD GARDENS NURSING HOME BALTO, CITY N/A										
Ĕ	RESIDENCE OF DECEDENT	TOND.	110 11	OPIL		DADIO, C	TII		N/	A	
Ĭ.	10a. STATE 10b. COUNT	Y		10c, CITY	TOWN OR LE	CATION				10	d. INSIDE CITY
DIRE	MARYLAND N	/A				DATEO O	Tomas				LIMITS?
	10e. STREET AND NUMBER	/ []				BALTO, C	T.T.X				YES 2 NO
FUNERAL						101. ZIP CODE			10g. CITIZEN	OF WHA	T COUNTRY?
	1504 N. EDEN	ST.				2121	3		T	J.S.	Δ
5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S	. ARMED	13. WAS	DECENDENT OF HISPA	NIC ORIGIN?	Specify Yes o		-	American Indian,
	1 Never Married 2 Married	FORCES? 1 IF YES, GIVE W			If yes	, specify Cuban, Mexic	an, Puerto Ric	an, etc.)		Black, W	/hita, atc.
B	3 Wildowed 4 Divorced	OCT . 24				YES 2 NO Spec	ny:			Specify:	BLACK
0	15. DECEDENT'S EDU			O JAN.	19/4		1 400 44				DIMON
	(Specify only highest grade	completed)	101	(Give kind of w	ork done during	most of working	16b. K	IND OF BUSIN	NESS/INDUST	TRY	
<u>ا</u> ا	Elementary/Secondary (0-12)	College (1-4 or 5+	+)	life. Do NOT use	retired.)						
	4TH	N/A	P.	ARKING	ATT	ENDANT		GARA	AGE		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				1100-0407	16. MOTHER'S N	AME (First. Mid	die, Maiden S	umame)		
EC	ALBERT MC CI	LINTON							,		
8	19a. INFORMANT'S NAME (Type/Print)	THIOM				IRENE	ANDE	RSON			
2	JAMES JOHNSON	J				et and Number or Rura					
- 1	UAMES JUHNSON	V		1010	WITH	ERSPOON	RD.	BALTO	O,MD.	2	1212
	20a. METHOD OF DISPOSITION		20b. PL/	CE AND DATEO			DATE		ATION — City		
	X N Burial 2 ☐ Cremation 3 ☐ Ram 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	cemetery	, crematory or oth	er place)	7-1	1-95				
	21. SIGNATINGE OF FUNERAL SERVICE LI		- GAR	RISON		T VET	CEM	LOWIN	NGS M	TLL	S. MD
Ì	21. SIGNAL OF FUNERAL SERVICE LI	CENSIA		0		E AND ADDRESS OF F					
	CALVIN B. SCRUGGS FUNERAL HOME										
- 1	1412 F DEFETON OF PALMO NO 21212										
	23. PART I. Enter the diseases, prehock, prheart failure. IMMEDIATE CAUSE (Fine) disease prepondition	complications that List only one cau	caused the	e death, Do no	1141	2 F DD	FCTOM	CTP	DAIM	0 14	D 2121 Approximate
ATION	anock, or neart failure.	a. ACU DUE TO	ITE MY	line.	14] of enter the	2 F DD	ESTON ch as cardle	CTP	DAIM	0 14	Approximata
FICATION	IMMEDIATE CAUSE (Finel disease or condition reaulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	a. ACU DUE TO DUE TO	OR AS A CO	Ine. Ocard NSEQUENCE OF	ial	2 E PR mode of dying, su	ESTON ch as cardle	CTP	DAIM	0 14	Approximata
TIFICATION	shock, or near failure. IMMEDIATE CAUSE (Fine) disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	a. ACU DUE TO DUE TO	OR AS A CO	line. /ocard	ial	2 E PR mode of dying, su	ESTON ch as cardle	CTP	DAIM	0 14	D 2121 Approximata Interval Betw
ERTIFICATION	IMMEDIATE CAUSE (Finel disease or condition reaulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	a. ACU DUE TO DUE TO	OR AS A CO	Ine. Ocard NSEQUENCE OF	ial	2 E PR mode of dying, su	ESTON ch as cardle	CTP	DAIM	0 14	Approximata
- CERTIFICATION	shock, or near failure. IMMEDIATE CAUSE (Fine) disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events rasulting in death) LAST	a. ACU DUE TO DUE TO DUE TO d.	OR AS A COM	Ine. OCATA NSEQUENCE OF	ial	2 F. PR mode of dying, su	ESTON ch as cardle tion	ST.	RAT.T	CO, M	Approximate Interval Betwoen and D
	shock, or near failure. IMMEDIATE CAUSE (Fine) disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	a. ACU DUE TO DUE TO DUE TO d.	OR AS A COM	Ine. OCATA NSEQUENCE OF	ial	2 F. PR mode of dying, su	ESTON ch as cardle tion	CTP	RAT.T	24b. WE	Approximate interval Betwonset and D
	shock, or near failure. IMMEDIATE CAUSE (Fine) disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events rasulting in death) LAST	a. ACU DUE TO DUE TO DUE TO d.	OR AS A COM	Ine. OCATA NSEQUENCE OF	ial	2 F. PR mode of dying, su	ESTON ch as cardle	ST c or respira	RAT.T	24b. WE	Approximate Interval Betwonset and D
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IMPORTANT: If

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PHYSICIAN: MEDICAL

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27. MANNER OF DEATH

1 Natural

2 Accident

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THE HOSPITAL DR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after	무용
U Ti	E FILE
-	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 be filed within 72 hours after death with the State Dept, of Health and Mental Hypiene prior to burlal, cremation, or removal.
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 2: 4. SOCIAL SECURITY NUMBER 6. AGE (in yrs. last birthday) 5 SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH A. BIRTHPLACE (State or Foreign March 23. 1 - M 2 X F 92 220-44-3719 1903 Maryland 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH NON N/A RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland N/A Baltimore 1 X YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4422 Parkside Drive 21206 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or Noif yes, specify Cuben, Maxican, Puerto Rican, etc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married 3 Widowed 4 Divorced White 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 8 +) years Secretary Bank 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surname) Frank Neumann Alvina Wagandt 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris V. Louis (Daughter) 4422 Parkside Drive. Baltimore, Md. 21206 20e METHOD OF DISPOSITION
1.0 Burlel 2 Cremetion 3 Re
4 Donation 5 Other (900city) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State Parkwood Cemetery 7/8/95 Baltimore. Maryland 21. SIGNATURE OF FUNERAL SERVICE LIGHNISES 22. NAME AND ADDRESS OF FACILITY
Schimuner Funeral Home 3331 Brehms Lane, Baltimore, Md. 21213 23. PART I. Enter the diseases, or compricetions that ceused the death. Do not enter the mode of dying, such sa cardiac or reapiretory arrest, Approximate shock, or heart failure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition · RESPIRATORY FAILURE 2 DAYS resulting in death) DUE TO (OR AS A CONSEQUENCE OF) b. PNEUMONIADUE TO (OR AS A CONSEQUENCE OF): 2 DAYS Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST

PART II. Other algnificent conditions contributing to death but not reaulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 - YES 2 5 NO

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24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO I UNCERTAIN I 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) OTHER: 1 YES 2 NO

HOSPITAL:
1 Xinpatient 2 ER/Outpatient 3 DOA 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF

4 - Nursing Home 5 - Residence 6 - Other (Specify)

28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO

26a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

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1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

29c. LICENSE NUMBER	
MANUSITARESTA HANIGIA A ATLAYS	15%

38. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

- 1	ZVQ.	DALE SIGNED (Month, Day, 19ar)	
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32. REGISTRAR'S SIGNATURE

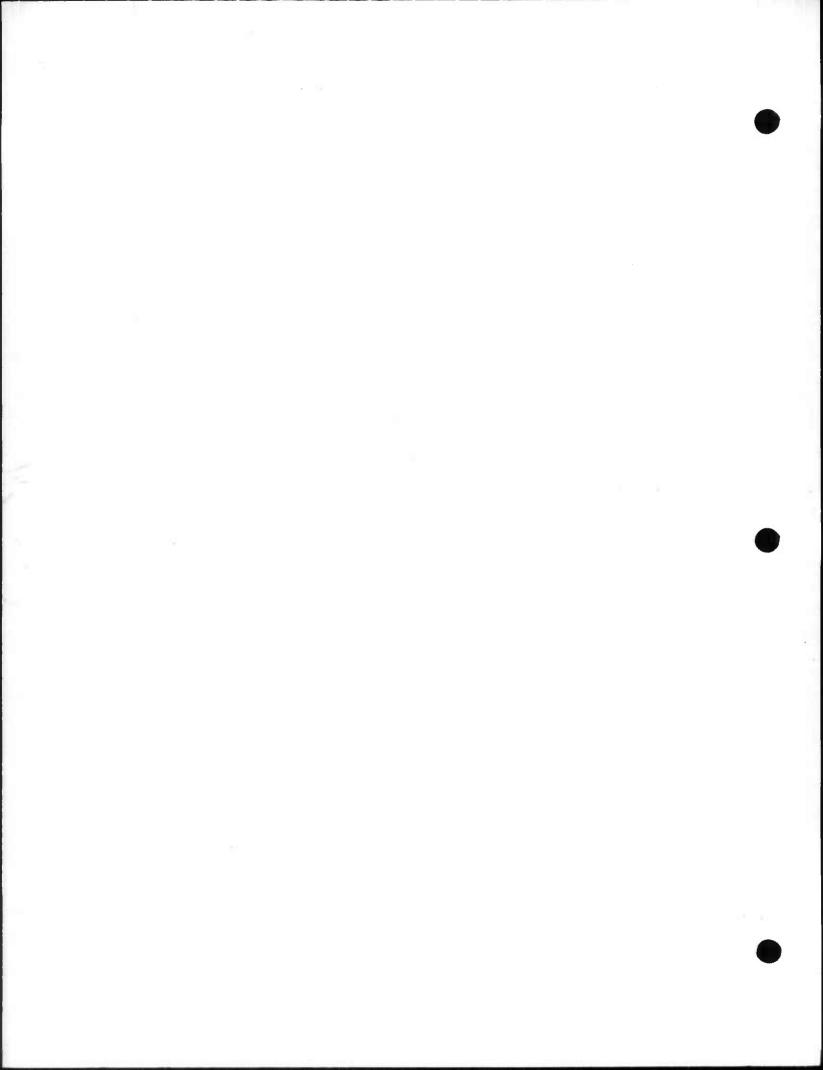
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing A hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	AY YE	3. TIME OF DEATN
	WILLIAM	D.	MCM	ILLAN			. 995	7:25 PM
	4. SOCIAL SECURITY NUMBER	1.1.1.1	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year)	8. B	HRTHPLACE (State or Foreign ountry)
	355-16-3309 A	1 🔀 M 2 🗆 F	75 YRS.			May 15, 1	920 Pe	ennsylvania
<u>~</u>	90. FACILITY NAME (If not institution, give : THE JOHNS HOPKI				R LOCATION OF DE	ATN	9c. COUNTY (
5	RESIDENCE OF DECEDENT	NS HUSPITAL		BALTIM	ORE CITY		N/	'A
DIRECTOR	10a. STATE 10b. COUNT	Υ	10c. CiT	Y, TOWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?
		oward	F	ort Laud	erdale			1 TES 2 X NO
RAL	10e. STREET AND NUMBER	. 1		101.	. ZIP CODE			OF WHAT COUNTRY?
FUNERAL	4305 Sterling Ro	12. WAS DECEDENT EVER			33304			S. A.
	1 Never Married 2 Married	FORCES? 1 Y YES	2 NO	If yes, spe	ENDENT OF NISPAN scify Cuban, Maxica 2 🕅 NO Specify	IIC ORIGIN? (Specify Yearn, Puerto Rican, atc.)	1	RACE — American Indien, Black, White, atc.
ВУ	3 Wildowed 4 Divorced	WWII		I TES	Z IAI NO Specify	,	,	White
TED	16. DECEDENT'S EDU (Specify only highest grade	ICATION completed)	(Give kind of t	USUAL OCCUPATIO	ON st of working	16b. KIND OF BU	SINESS/INDUSTR	îY Y
LE L	Elementary/Secondary (0-12) 5th Grade	College (1-4 or 5+)	Dozzina	o retired.) Contracto	0.30	Colf Em	-11	Contractor
COMPLET	17. FATNER'S NAME (First, Middle, Last)		raving	Jontract		ME (First, Middle, Maiden	1 2	Contractor
	George McMillan					ME (First, Middle, Maiden Docherty	Surname)	
BE (19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a		Soute Number, City or Tow	m, Stete, Zip Code)
5	Margaret McMilla	n (Wife)	4305	Sterling	Road, Fo	ort Lauder	dale, F	Torida 33304
	20a. METHOD OF DISPOSITION 1 □ Burlel 2 □ Cremation 3 🂢 Rem	novel from State	b. PLACE AND DATE (metery, crematory or o	OF DISPOSITION (Na	me of	DATE 20c. LO	CATION — City of	or Town, State
	4 Donation 5 Other (Specify)	A	rlington	Cemetery			xill Hi	11, Pa.
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE			imunek Fi	oury uneral Hom	ie	
	- 10 m H CH	W						Md. 21213
	23. PART I. Enter the diseases, or ahock, or heart fellure.	complications that cause List only one cause on	d the death. Do reach line.	not enter tha mod	de of dying, suci	h as cardiac or resp	iratory arrest,	Approximate interval Between
	IMMEDIATE CAUSE (Finel disease or condition	0000						Onset and Death
	resulting in death) a. SEPS1 S DUE TO (OR AS A CONSEQUENCE OF):							
Z	Company to continue to LINER FRILLIE							
CERTIFICATION	Sequentially list conditiona, if any, leading to immediate		A CONSEQUENCE OF					
<u>S</u>	cause. Enter UNDERLYING CAUSE (Disease or injury	· VIRAL HE	SPATITIS	5 13				15 YEARS
E	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF	ቫ :				
Ü		d						
¥	PART II. Other aignificant condition	ne contributing to death	but not reaulting	in the underlying	cause given in	Part I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă						1 🗀 YES 2	ا کولات	COMPLETION OF CAUSE OF DEATH?
Σ	DID TODA CCO LICE CONT	DIDLITE TO CALLE	NE DE 4711 1/2					1 TYES 2 NO
AN	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUSE O	26. PLACE OF DEAT		UNCERTAIN	1 Dr		
SC	EXAMINER?	HOSPITAL:		OTHER:	s 5 Residence	e - Other Country		
PHYSICIAN: MEDIC	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIM	E OF 28c. INJU	URY AT	28d. DESCRIBE NOW I	NJURY OCCURE	0
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ	M 1 Y	PIK? PES 2 NO			
	3 Suicide 8 Could not be	28e. PLACE OF INJUR building, atc. (Spi	Y — At home, farm, s	street, factory, office		281. LOCATION (Street : City or Town, State)		iral Route Number,
COMPLETED								
MPL		ICIAN: To the best of my know						
8		ER: On the basis of examination	on and/or investigation	n, in my opinion, de	eath occured at the	time, date and place, an	nd due to the ceu	se(a) and manner as stated.
出	29b. SIGNATURE AND TITLE OF CERTIFIE	indon i	mi		29c. LICENSE NUM	BER 7	29d. DATE SIG	NED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WI	O COMPLETED CAUSE OF D	EATH (ITEM 27) (Type,	Print)	NCI	ווכ	-100	כדרו ני די
	DE KANDO	PARI, MI			4 Was	FE STRE	er . 134	YOMORE, MD
	31. DATE FILED (Month POPOLS	32. AEGISTRAR'S SI	NATURE				_, , , ,	4 00
- //	0000 11000	WHITE WAR	7044					



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

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9055,

31. DATE FILED (Month, Day, Year)

JUL 0 7 1995

Chevrolet Drive,

т 1	EM: 21. & 22, PER F.H. F.	TIM 6.725 7/7/05 +	+					9	J 6	4004	0
		STATE OF MARYLAND /	DEPARTMEN			MENTAL HY	GIEN	Ε			
	REGISTRAR	CE	RTIFICAT	E OF	DEATH	RE	G. NO				
	1. DECEDENT'S NAME (First, Middle, Last)	4				2. DATE OF DE	EATN D	AY	YEAR	. TIME OF DEA	
	Raytield Mat	thews				July	4	19	95	7:30	AM
ll	The state of the s	770				7. DATE OF BII (Month, Day,			8. BIRTNPL Country)	LACE (State or F	oreign
L	243-26-9616	RM2□F 82	YRS. MONTHS	DAYS	HOURS MIN.	4-6	- 1	13	N	.C.	
	9e. FACILITY NAME (If not institution, give street		9b. CIT	Y, TOWN	OR LOCATION OF DE				NTY OF OEA	TN	
8	Frederick Villa Ni	ursing Center	- C	utor	sville			Bal	timo	re Cou	vint
ECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	1									
DIRE	10e. STATE 10b. COUNTY	NA	10c. CITY, TOWN	OR LOCAT	TION				1	Od. INSIDE CITY	*
	1010,	1/11	JAH.	ומון	TRE				1	YES 2	NO
ERAL	100. STREET AND NUMBER	DAIL OF		101	. ZIP CODE	n		10g. CITI	ZEN OF WH	AT COUNTRY?	
買	414 ATTENT	カイド ライ			411	9		U	SA.		
FU		. WAS DECEDENT EVER IN U.S. ARI FORCES? 1 TYES 2 TO) 13.	WAS DEC	ENDENT OF NISPAN	NIC ORIGIN? (Spi	etc.)	or No-	14. RACE -	- American Indi White, etc.	len,
BY I	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DATES			2 NO Specify		0101)		Specify:		
								l	DL	ACK	
TED	15. DECEDENT'S EDUCATI (Specify only highest grade com-	npleted) (Gi	CEDENT'S USUAL Ove kind of work done Do NOT use retired.	during mo		16b. KIND	OF BU	SINESS/IND	USTRY		
"	Elementary/Secondary (0-12)	college (1-4 or 5+)	MECHA!			I A	VI	15 (AR		
COMPLET	16	/	TELAN	VIC							
	17. FATHER'S NAME (First, Middle, Last)	1.16			18. MOTHER'S NA	ME (First, Middle,	Maiden	Sumame)	7727	5.16	
8		WS			44	IE MY	18/	14	1/11	EWS	
2	190 INFORMANT'S NAME (Type/Print)	TTHEWS	MAILING ADDRES	S (Street	nd Number or Rural	Route Number, Cit	y or Tow	n, State, Zip	Code)	220	
	LUNE! IA I'M		/1 /YI	-41	-VER 9	1100	41	PIU	121	-49_	
	20s. SEPTIOD OF DISPOSITION 1 Surfai 2 Cremation 3 Removal	from State 20b. PLACE A	ND DATE OF DISPO	SITION (NE	ame of	a Vala	20c. LO	CATION -	City or Town	n, State	
	4 □ Donation 5 □ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENS	1 4000	VHIM	//\		12/47	SPA	7110	VPS-	. / 1//,	D A
		Y P. MARGH PER D.	V.R. 22	LOSEI	NO ADDRESS OF FA	WN IR	समा जनस	TERAT	HOME	RAL HUNE	. P.A.
	JA MAG	ma	7	别请	EDAIL TON P	ASS BAL	TIM	BALT	IMORE D. 212	3000 - 2	1223
	23. PART I. Shifer the differes, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory erreat, Approximate								nata		
	ehock, or heert feilure. List	t only one ceuee on each line.								Onset sn	
ll	disease or condition	or condition .									
1 1	resulting in deeth) e	Bronchopnel DUE TO (OR AS A CONSECU								one	wee
_		Stroke								Many	mor
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	OUE TO (OR AS A CONSEC	UENCE OF):							rially	mor
🕺	ceuse. Enter UNDERLYING	Hypertensio	nn							Yea	re
틸	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONSEC								I Ed.	LS.
ᇤ	reaulting in deeth) LAST										
ᄬ										†	
A	PART II. Other significant conditions of Insulin Deper	ontributing to deeth but not re adant Diabete	esulting in the u	inderlyin	g cause given in	Pert i. 24a.	WAS AN	AUTOPSY		VERE AUTOPSY F	
음		- DIADGE		ı Çu.	·	1 0	YES 2	≥ ZNO		COMPLETION OF DEATH?	CAUSE
MEDICAL									1	YES Z	NO
ä	DID TOBACCO USE CO	NTRIBUTE TO CAUS	E OF DEA	TH Y	ES NO	Γ *					
<u> </u>	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			28. PI	LACE OF DEATH (Ch	eck only one)					
PHYSICIAN:	11	OSPITAL: Inpatient 2 ER/Outpatient 3	DOA 4 Nu		ne 5 🗆 Reeldence	6 Other (Spe	cify)				
主	27. MANNER OF DEATH	28e. OATE OF INJURY	26b. TIME OF	28c. IN.	IURY AT	28d. OESCRIBI		INJURY OC	CURED		
ВУ	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY		YES 2 NO						
	2 Accident Investigation 3 Suicide 8 Could not be	260. PLACE OF INJURY - At hor	me, farm, atreet, fac	ctory, offic	•	281. LOCATION		and Number	or Rural Ros	ute Number,	
TED	4 Homicide determined	building, etc. (Specify)				City or Tow	n, State,				
1 1 1	29a. CERTIFIER 1 X CERTIFYING PHYSICIAL	N: To the best of my knowledge, dea	oth occurred at the	Non det	and place and a	la tha constant	i de la composición dela composición de la composición dela composición de la compos	e a elimin	w7	,	
COMPLET		n: to the best of my knowledge, dec In the bests of examination and/or i								and managed to	atasta d
8	4	171		-product s			natural, ski				
닒	296. SIGNATURE AND TITLE OF CONTIFIER	6			29c. LICENSE NUN					Aorett, Day: Year)	
D30469.						▶ July 5 1995.				95.	

COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) N. B. Vel. Drive, #Suite 100, Ellicott

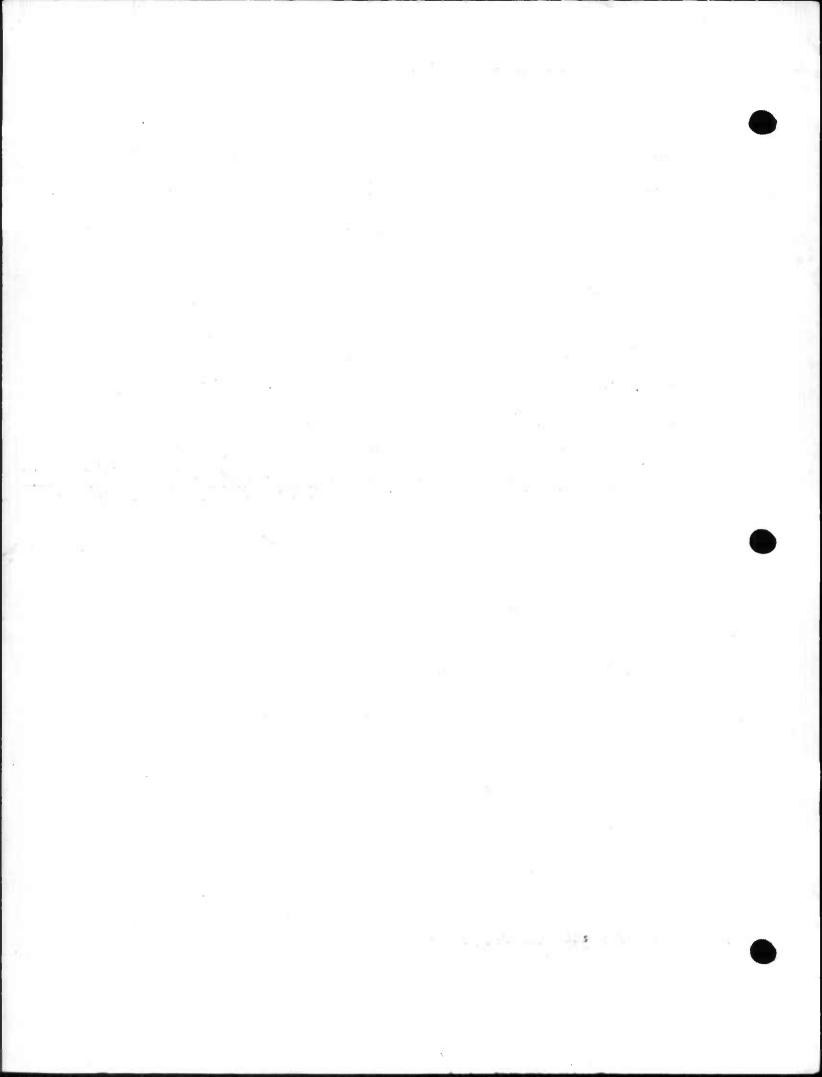
32. REGISTRAR'S SIGNATURE

Vellanki, ott City,

MD.

MD 21042.

DHMH-16 Rev 1/89



2, 3 should

31. DATE FILEO (Month, Day, Year)

	nsit permit. Pages 1,	
If or attending physicial	for use as the burial-tr	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or after	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	notified at once.
death. Page 6 may be	funeral director, page	IMPORTANT: If flem 28 is marked, or flem 23 shows any injury, or other traumatic event, the medical examiner must be notifi
d within 24 hours after	impletely filled in by the cremation, or remova	event, the medical
certificate be execute	nding physician and co Hygiene prior to bunal	or other traumatic
requires that the death	een signed by the atte	shows any injury,
G PHYSICIAN: The law	er this certificate has the with the State Dept	narked, or item 23
SPITAL OR ATTENDIN	JERAL DIRECTOR: After in 72 hours after dea	IT: If Item 28 is m.
TO THE HOS	TO THE FUN be filed with	IMPORTAN

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MONTH 07 YEAR ENE No 350 a. 4. SOCIAL SECURITY NUMBER SEX AGE (In yrs. lest birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign -50-4436 1 DM 2 - F YRS. 9c. COUNTY OF DE 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 10a. STATE 10b. COUN 10c. CITY 10d. INSIDE CITY LIMITS? 1 YES 2 THO FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cubin, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian. Black, White, atc. 2 Married 1 Never Married IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced 1966 1969 입 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY E College (1-4 or 5+) COMPL MOTHER'S NAME (First, Middle. 띪 19b. MAILING ADDRESS (Street and Nur 8-349 G.Th 9 PLACE AND DATE OF DISPOSITION seases, or complications that ceused the desth. Do not enter the mode of dying, such sa cardiec or respiretory strest, **Approximats** k, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Finel Onset and Death disesse or condition Scleroderma 45kmic resulting in death) DUE TO (OR AS A CONSEQUENCE OF) MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) thet initieted events resulting in deeth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) OTHER: 1 YES 2 NO 1 Impatient 2 ER/Outpatient 3 DOA Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28a, DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural Pending Investigation м 1 YES 2 NO BΥ 2 Accident 28e. PLACE OF INJURY --- At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, BIONATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER B 29d. DATE SIGNED (Month, Day, Year) 9 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print,

South Gre

32 REGISTRAR'S SU

MURC

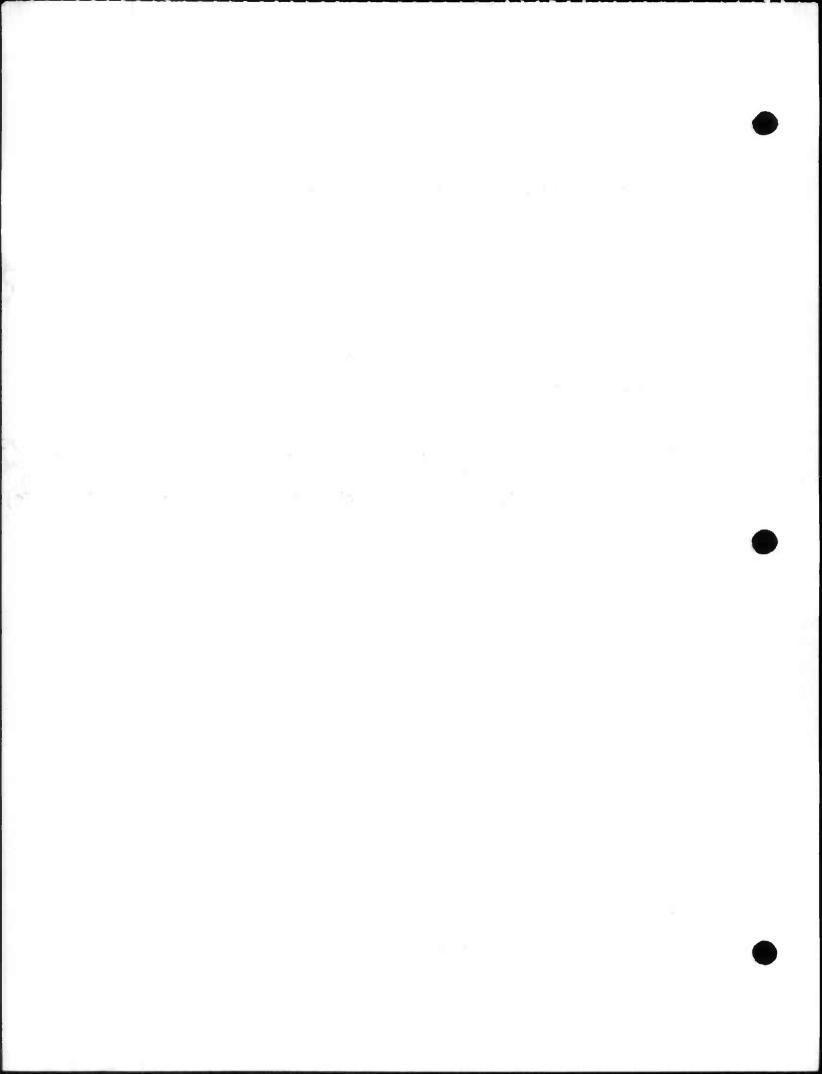
TO BE COMPLETED BY FUNERAL DIRECTOR

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

CIAN: The law requires that the death certificate be executed within "c" hours after death. Page 6 may be retains entificate has been signed by the attending physician and completely filled in by the funeral director, page 5 shouthe State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPURIANT: IT IEM 25 IS MARKED, OF ITEM 25 SHOWS ANY INJURY, OF OTHER TRAUMANC EVENT, THE MEDICAL EXAMINER MUST BE NOTITIED AT ONCE.
--	--

FOR STATE REGISTRAR		STATE OF MARYL	AND / DEF	ARTME	NT OF HI	EALTH AND DEATH	MENTA	AL HYGIENE REG. NO.			
1. DECEDENT'S NAME (First	, Middle, Last)	net Mula	eahu			-	2. DAT	E OF DEATH	- 0	3. T	TIME OF DEATH
4. SOCIAL SECURITY NUMBER			In yrs. last bigin	lay) IF UN	DER 1 YEAR	IF UNDER 24 HRS.	7 DAT	E OF BIRTH	8.		CE (State or Foreign
220-05-492	_	□ M 2 9 F 96	YR			HOURS MIN.		23, 18	99	Mary	land
Harford Gar	-	,	Center	96. C		location of D Itimore		,	9c. COUNTY	of DEATH	
RESIDENCE OF DEC		Traicscent	ocircei		Du	TOTILOTE	010	,	-	1/ α	
Maryland	10b. COUNTY	n/a	10c.		n or Location	e City					. INSIDE CITY LIMITS?
10e. STREET AND NUMBER					10f.	ZIP CODE			10g. CITIZEI		
1618 Ralwor	th Road				_	21218	3			USA	
11. MARITAL STATUS		. WAS DECEDENT EVER II	U.S. ARMED	1		NDENT OF HISPA			or No- 14	. RACE - A	American Indian,
1 Never Married 2 3 Wildowed 4 Divo		IF YES, GIVE WAR OR D				cify Cuben, Mexico 2 X NO Speci		Rican, atc.)		Specify: White	
	EDENT'S EDUCATI	ON	MA DECEDE	1	20011717171				1		5
(Specify only Elementary/Secondary (0	y highest grade con	npleted)	(Give kind life. Do NO		ne durina most		16	b. KIND OF BUSI	NESS/INDUS	TRY	
12	P12)	ollege (1-4 or 5 +)	Sale	spers	on			Hech:	t Co.		
17. FATHER'S NAME (First, M	iddle, Last)			·		16. MOTHER'S NA	AME (First,	Middle, Meiden S	urneme)		
George Wit	thauer					Anna Fr	rye				
19e. INFORMANT'S NAME (7			19b. MAII	ING ADDR	ESS (Street en	d Number or Rural	Route Nur	mber, City or Town,	Stele, Zip Co	ode)	
Mrs. Mary E	. Drake		61	Eastf	ord Co	ourt Ba	altir	more, Ma	arylar	nd 21	234
20e. METHOD OF DISPOSITI 1X Burlel 2 ☐ Cremetic 4 ☐ Donation 5 ☐ Other	n 3 🗆 Removal	from State 20b	PLACEANDDA	or other place	osition(Nam	l Cem. 7	DA	TE 20c. LOC	ation – chi		ryland
21. SIGNATURE OF FUNERA	L SERVICE LICENS		<u> </u>	2	2. NAME AND	ADDRESS OF FA	CILITY	Jo Dai	CIMOIC	ria	yrana
· Meo	keel)	Buck				J. Ruck, rford Roa		ltimore.	Marvla	nd 21	214
23. PART i. Enter the di	iseases, or com	pilcetions that caused only one cause on e	the death.	o not ent	ter the mod	e of dying, suc	ch as ca	rdiec or respin	story erres	ι,	Approximata
IMMEDIATE CAUSE (Fir		only one cause on e	4		- 1			1	, .	į	Onset and Death
disease or condition	→ a	Allew 3Cl	Moli	C (ard	io Vas	cul	er a	we	rae	5 Hours
	220	Digate	T	c Orj:						ľ	
Sequentielly list conditi		DUE TO (QR AS A	CONSEQUENC	E OF):						— i	
cause. Enter UNDERLYI CAUSE (Disease or inju	ING										
that initieted events		DUE TO (OR AS A	CONSEQUENC	E OF):							
resulting in death) LAS	d										
PART ii. Other elgnifica	nt conditione c	ontributing to death b	ut not reauiti	ng in the	underlying	ceuse given in	Part i.	24a. WAS AN A	UTOPSY	24b, WER	E AUTOPSY FINDINGS
								PERFORM			LABLE PRIOR TO
								1 TYES 2	Muo		YES 2 NO
DID TOBACCO U	SE CONTRIB	UTE TO CAUSE O	F DEATH	YES	NO 🖾	UNCERTAI	ΝП				190.00
25. WAS CASE REFERRED TO EXAMINER?			28. PLACE OF I								
1 TES 2 XONO		OSPITAL: Inpatient 2 ER/Outp	etlent 3 🗆 DO	A 4XX		5 Residence	6 🗆 Oth	er (Specify)			
27. MANNER OF DEATH	Pending	28e. DATE OF INJURY (Month, Day, Year)	28b.	TIME OF INJURY	28c. INJU WOR		28d. DE	SCRIBE HOW IN	JURY OCCUP	ED	
	rending Investigation			М		S 2 NO					
	Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, le	m, atreet, l	ectory, office			CATION (Street en y or Town, State)	d Number or	Rural Route	Number,
29e. CERTIFIER (Check only	IFYING PHYSICIAI	: To the best of my know	edge, death oc	curred at th	e time, date e	nd place, and due	to the ca	euse(e) end menn	er ee stated.		
		In the beste of examination								euse(s) end	menner ee stated.
29b. SIGNATURE AND TITLE	OF CERTUFIER	Tipu	nan	en		29c. LICENSE NU	MBER /		29d, DATE S	GNED (Mag	ph, Day, Year) 5
30. NAME AND ADDRESS OF	PERSON WHO CO	WPLETED CAUSE PROE	TH (TEM 27)	Type, Print)	+700	Han	030	& Rd	B	the	io Co
31. DATE FILED (Month, Day.		32. REGISTRAR'S SIGN	ATURE		`	-	' He	d-2	121	4	
JUL 0 7199	5 Juli	Shudoorfor	2.00								- 1



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within months and refer to the first of the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

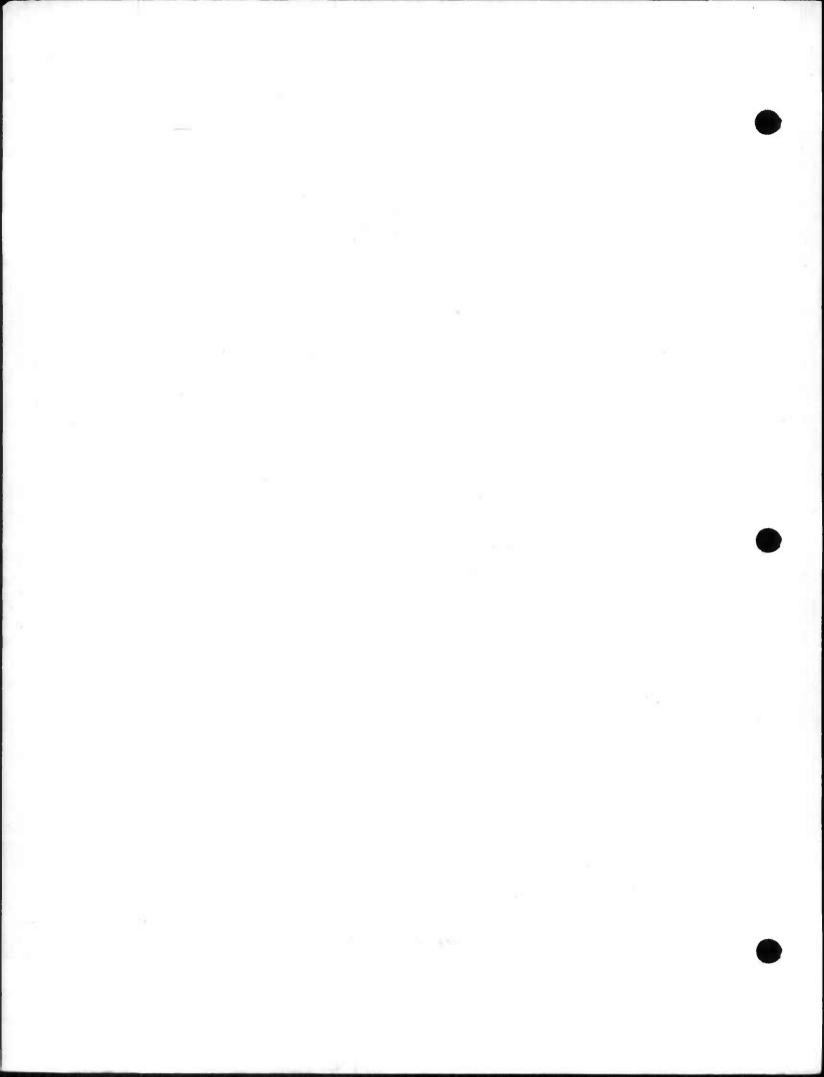
BALTIMORE, MARYLAND 21215-0020

1 - STATE STATE OF

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAN	CERTIFICATE OF DEATH	REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last) Irvin E. Porter		2. DATE OF DEATH MONTH DAY June 24 27 19	3. TIME OF DEATH						
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE	(In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. YRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH 8.	BIRTHPLACE (State or Foreign Country)						
	9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF D	0000	VI						
TOR	St. Agnes Hospital	Baltimore	SE COUNTY	/A						
DIRECTOR	10e. STATE 10b. COUNTY	10c. CITY, TOWN OR LOCATION ROUTENOCO		10d, INSIDE CITY LIMITS? 1 YES 2 NO						
FUNERAL	100. STREET AND NUMBER	101, ZIP CODE	10g. CITIZEN	OF WHAT COUNTRY?						
N.		100		Α						
BY FU	11. MARITAL STATUS 1 Never Married 2 Married 2 Married 3 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 M YES 2 NO If yes, specify Cuben, Mexicen, Puerto Rican, etc.) 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-It yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 15. Yes 2 No Specify: Black									
	15. DECEDENT'S EDUCATION	188. DECEDENT'S USUAL OCCUPATION	18b. KIND OF BUSINESS/INDUST							
COMPLETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) NA	(Give kind of work done during most of working life. Do NOT use retired.) COPRECTIONAL OFFICE	City Po							
N N	17. FATHER'S NAME (First, Middle, Last)		ME (First, Middle, Malden Surname)	Cil						
BE C	Irvin Porter Sr.	Isa	belle Walk	er						
TO BE COM	19a. INFORMANT'S NAME (Type/Print) May I un Porter	19b. MAILING ADDRESS (Street end Number or Rural	Route Number, City or Town, State, Zip Coo	01009						
	209 METHOD OF DISPOSITION 20	b. PLACE AND DATE OF DISPOSITION (Name of	DATE 20c. LOCATION City	or Town, State						
		metery, cremetory or other place)	7-3-95 OWNINGS	Mills Md.						
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FA	CILITY							
	Jala Mary		n Avenue Baltimo	ee, Md 21215						
	23. PART I. Eritar tha diseases, or complicationa that cause shock, or heart failure. List only one cause on a	d the death. Do not enter the mode of dying, suc	h as cardiac or respiratory arrest							
	IMMEDIATE CAUSE (Final	aovii iiid.		intarvai Between Oneat and Death						
DICAL CERTIFICATION	disease or condition resulting in death) Sepsis			3 days						
z	Vibrio V	A CONSEQUENCE OF): Vulnificus								
ATIO	it any, leading to immediate	A CONSEQUENCE OF):								
FIC	CAUSE (Disease or Injury C. Due TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	that initiated events reaulting in death) LAST d									
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS									
EDICAL	Cirrhosis		PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE						
: MEC	Emphysema OF DEATH?									
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	26. PLACE OF DEATH (Ch								
HYS	27. MANNER OF DEATH 28s. DATE OF INJURY	patient 3 DOA 4 Nursing Home 5 Residence 28b. TIME OF 28c. INJURY AT	8 Other (Specify) 28d. DESCRIBE HOW INJURY OCCUR	ED						
ВУ Р	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	INJURY WORK? M 1 YES 2 NO								
ED.		Y — At home, farm, street, factory, offica	281. LOCATION (Street and Number or F City or Town, State)	lurel Route Number,						
ĽE	29a. CERTIFIER 1 🔀 CERTIFYING PHYSICIAN: To the best of my know	wledge, death occurred at the time, date and place, and due	to the councie) and manner as stated							
COMPLETE		on and/or investigation, in my opinion, death occured at the		ruse(s) and manner as stated.						
BE C	296 SIGNATURE AND TITLE OF CERTIFIES	29c. LICENSE NUI		GNED (MorWi, Day, Year)						
TO BE COMPLE	Mitael & Pelazar	M) D09990	▶ Ju	ne 28, 1995						
-	Michael F Poleman M.D. Co									
	Michael E. Pelczar, M.D. – St 31. DATE FILED (Mooth. Dov. MANG QQS	• Agnes Hospital - 900 C	aton Ave., Balti	more. Md. 2122						
	31. DATE FILED (Mooth, Day, Marie 1995)	- 1 M								

DIVISION OF VITAL RECORDS, P.O. BOX 68760,



1, 2, 3 should

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

9000

							95	20	1550
FOR 1 - STATE REGISTRAR	STATE OF MA	ARYLAND /	DEPART	TMENT OF	HEALTH AND	MENTAL HYGIEN			
1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF OEATH		3.	TIME OF DEATH
	Pugh :	Sr.				July 5	199	YEAR 5	1:50am M
		B. AGE (In yrs. las	"	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLA	ACE (State or Foreign
213-03-2373	M 2 □ F	85	YRS.	WOMING DAYS	HOURS MIR.	sept. 21	190)	Ohio
9a. FACILITY NAME (If not institution, give street					OR LOCATION OF E			ITY OF OEAT	
Meridian - Fra	nklin	Woods		I	Rossvil	le	E	Balti	more
10a. STATE 10b. COUNTY			10c. CITY	TOWN OR LOCA	TION			100	d. INSIDE CITY
Md. Bal	timore			7	lowson			100	LIMITS?
10. STREET AND NUMBER 10. STREET AND NUMBER 10. STREET AND NUMBER 10. STREET AND NUMBER 10. STREET AND NUMBER									
922 Southerly	Road				2120	4	τ	JSA	
	. WAS DECEDENT	EVER IN U.S. AR	MED	13. WAS DE	CENDENT OF HISPA	NIC ORIGIN? (Specify Yes	or No.	14. RACE —	American Indian,
1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 FYES, GIVE WA	R OR DATES	10		pecify Cuben, Mexic S 2 X NO Spec	en, Puerto Ricen, etc.)		Black, W Specify:	hita, atc.
				l e				M	hite
15. DECEDENT'S EDUCATI (Specify only highest grade com	ON spieted)	(G	ive kind of we	SUAL OCCUPATION done during m	ION ost of working	16b. KIND OF BU	SINESS/INDI	USTRY	
Elementary/Secondary (0-12) c	college (1-4 or 5+)		Do NOT use			D 17	~ .	_	
17. FATHER'S NAME (First, Middle, Last)			teel	worker		Beth		91	
Matthew Pugh					The Control of the Co			ina	
19a. INFORMANT'S NAME (Type/Print)		191	h MARING	AODRESS (Street		lizabeth Route Number, City or Tow			
David Pugh Jr.									21220
20a. METHOO OF DISPOSITION	-	20h PLACEA		FOISPOSITION (N		Road Bali		e MD	
1 N Burial 2 □ Cremation 3 □ Removal 4 □ Donation 5 □ Other (Specify)	from State	cemetery cre	metary or oth	ler niecel		ery 7/7/9			
21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE	1 Dula	ney	22. NAME A	ND ADDRESS OF F	CITA /// A	D BA	LICIM	ore Ma.
DR TINI	10	01/,				uneral Ho			
23. PART i. Enter the disesses, or com-	our	ully	-11-2	300	Mace A	<u>ve. Balti</u>	more	Md.	
shock, or heart fallers List	only one cause	on pact line	ath: Do no	ot enter the me	ode of dying, su	ch as cerdiec or respi	ratory srre	est,	Approximate interval Between
iMMEDIATE CAUSE (Finel disease or condition	END C	This	De		DISEAS	-			Onset and Death
resulting in death)		OR AS A CONSEC			D12E4	, [week
_	002 10 (0	A A CONSEC	DOENCE OF	•					
Sequentially list conditions, if any, leading to immediate	DUE TO (O	R AS A CONSEC	DUENCE OF)	:					
cause. Enter UNDERLYING									
CAUSE (Disesse or injury that initiated events	DUE TO (O	R AS A CONSEC	DUENCE OF)	:					
resulting in deeth) LAST									
PART ii. Other significant conditions co	ontribution to d	eath but not n	acultine is	Abo condedute		nia. La mai		1	
Multiple Mye		outil Dat Hot I	esuiting in	the underlyin	ig cause given in	Part i. 24s. WAS AN PERFOR		AVA	RE AUTOPSY FINDINGS ILABLE PRIOR TO
I			0.0			1 🗆 YES 2	W NO		MPLETION OF CAUSE DEATH?
Coronary Av	tery I	SE OF DEA	<u> </u>	. D No F	Wiernzu			1 [YES 2 HO
25. WAS CASE REFERRED TO MEDICAL	OTE TO CAU			(Check only one		иПТ			
EXAMINER?	OSPITAL:			OTHEB					
27. MANNER OF DEATH	28a. DATE OF IN		28b. TIME		JURY AT	6 Other (Specify) 28d, DESCRIBE HOW II	N.IIIBY OCC	HEED	
1 Natural 5 Pending	(Month, Day,		INJU	RY W	YES 2 NO				
2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF	INJURY — At hor	me, ferm, at	reet, fectory, offic	ie	28f. LOCATION (Street a	and Number of	or Rural Route	Number
4 Homicide determined	building, at	u. (Specify)				City or Town, State)			
29a. CERTIFIER 1 CERTIFYING PHYSICIAN	: To the best of m	v knowledge de	ath occurred	at the time date	and place and do	to the neue-fol and		4	
(Check only									d manner ee stated
(Check only one) 2 MEDICAL EXAMINER: Or					death occured at the	time, data end place, an	d due to the	cause(a) en	
(Check only	n the beals of exer	mination and/or i	nvestigation			time, data end place, an	d due to the	SIGNED (Mo	d manner as stated. nth, Day, Year)

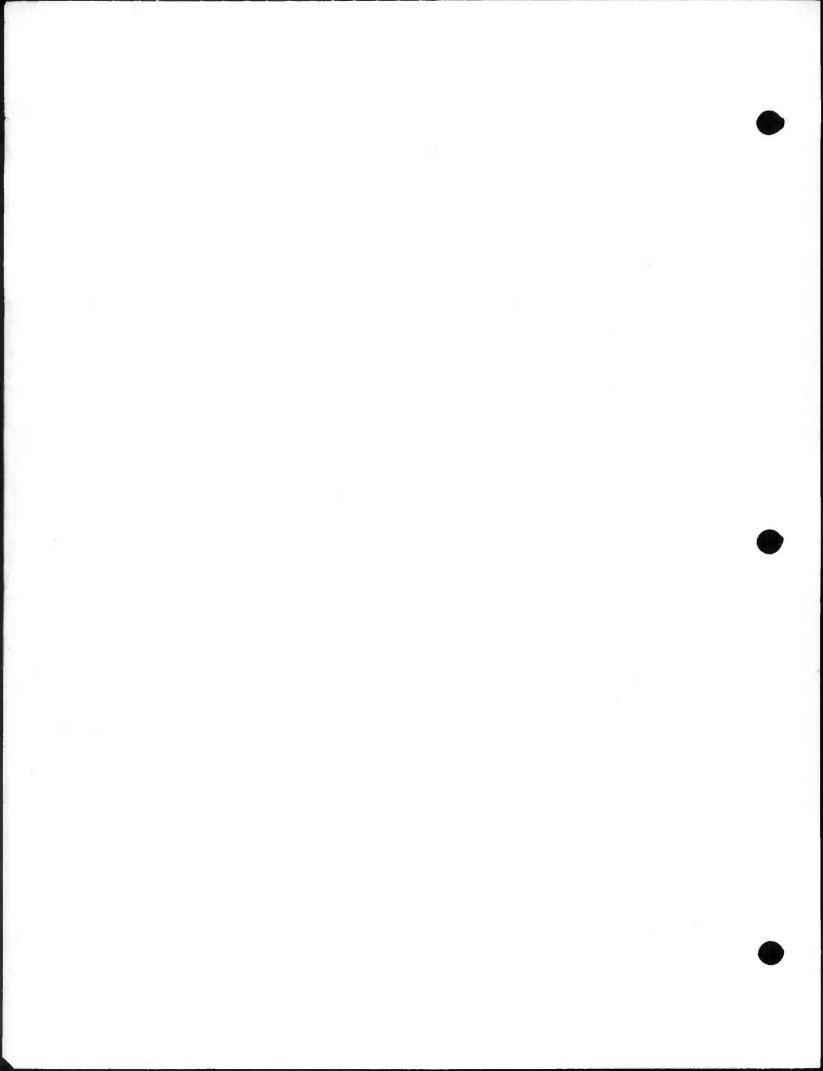
BALTIMORE MD

CANOL

SQUARE

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

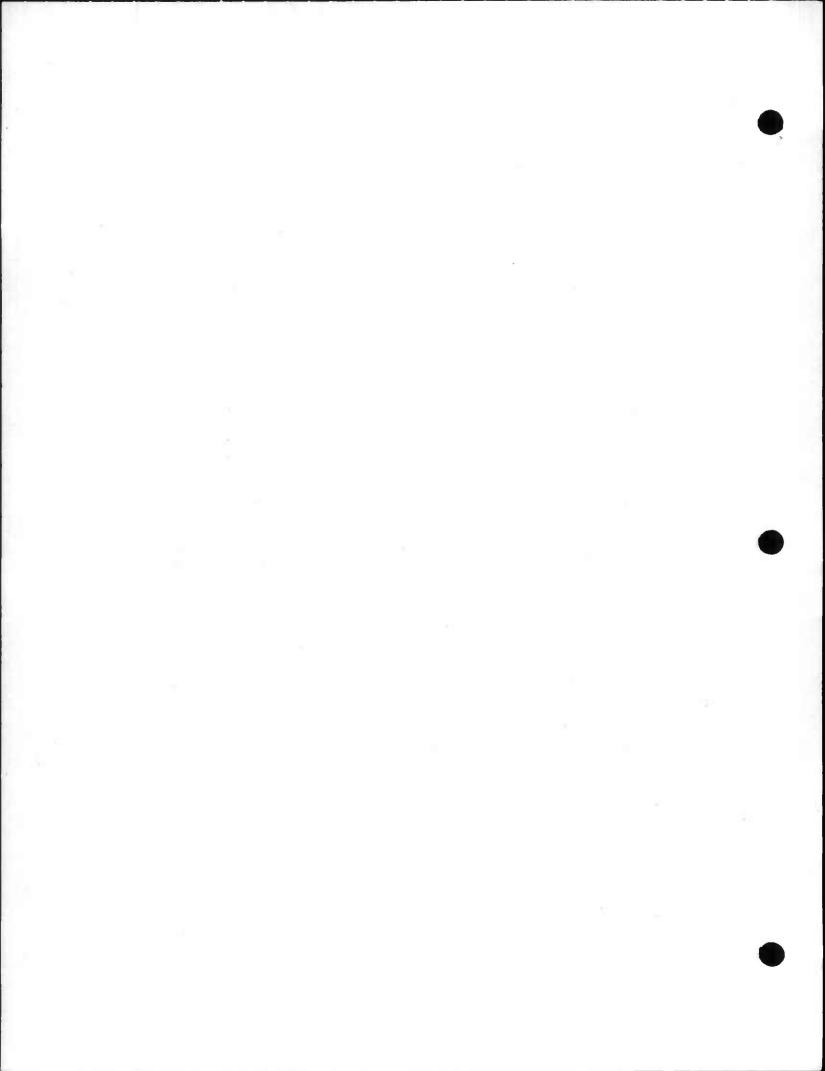
DRIVE



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMBI ETEN	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
l examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
the funeral director, page 5 should be detached for use as the val.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal.
er death. Page 6 may be retained by the hospital or attendin	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending

								000	
	1 - STATE REGISTRAR	STATE OF MAR	YLAND / DEI CERT	PARTMENT 0 FIFICATE (F HEALTH AND OF DEATH	MENTAL HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last) WARREN L	EROY PEA	RSON S	SR.		2. DATE OF DEATH	1 995	YEAR 8:15 A	
	4. SOCIAL SECURITY NUMBER 217-94-6273	5. SEX 6. A	GE (In yrs. lest birth		AR IF UNDER 24 HRS.	7. DATE OF BIRTH	- 1	BALTIMORE, MD	
	9a. FACILITY NAME (If not institution, give str	7474		9b. CITY, TO	WN OR LOCATION OF D	,	Y OF DEATH		
стон	969 COL	LINGTON A	VENUE	B	ALTIMORE	CITY		n/a	
DIRECTOR	10a. STATE 10b. COUNTY	DA. STATE 10h COUNTY			OCATION ALTIMORE		10d. INSIDE CITY LIMITS? YES 2 \(\text{NO} \) NO		
	10e. STREET AND NUMBER			10f. ZIP COOE		10g. CITIZEN OF WI			
FUNERAL	969 COLL	INGTON AV			21205		UNITE		
BY	X Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR O	ES X2 NO	If ye	occendent of HISPAI s, specify Cuban, Mexica YES 2 NO Specif		or No- 1	4. RACE — American Indian, Black, White, atc. Specify: BLACK	
	15. DECEDENT'S EOUCJ (Specify only highest grade of		16a. DECEOE! (Give kind	NT'S USUAL OCCUI d of work done durin OT use retired.)	PATION g most of working	16b. KIND OF BU	SINESS/INDU	STRY	
COMPLETED	Elementary/Secondary (0-12) 8 TH	College (1-4 or 5+)		nployed		nev	er wo	orked	
SO	17. FATHER'S NAME (First, Middle, Last)			.,,		ME (First, Middle, Maiden	Sumeme)		
BE	RICHARD E.	PEARSON S	R.	I NO ADDRESS (O	MAR	Y CFOWDE			
2	MARY PEARSON	19.			COLLINGTON			MORE, MD # 05	
	20a. METHOD OF DISPOSITION 1 © Burlet 2 Cremation 3 Remove 4 Donation 6 Other (Specify)			E OF DISPOSITION (Name of Other place) WE MORTAL PARK 7-5			20c. LOCATION — City or Town, Stata		
	1 Compation 2 Cremation 3 Removal from State Compation Compati							_N, MU	
L	Bemand D	Johnson	h	WM.	X C. MA	RCH FH11	01 E	. NORTH AVENUE	
	23. PART I. Enter the disesses, or co shock, or heart fallure. If	omplications that ceu list only one cause or	sed the desth. I	Do not enter the	mode of dying, suc	h ss cardisc or resp	ratory erres	st, Approximate	
			ii decii iiile.				-	Interval Between	
	IMMEDIATE CAUSE (Finsi disease or condition resulting in death)	Palmoner		bacton	um Arium	- Intraca		Interval Between Onset and Death	
		Palmonara Due to con p		obacten	un Avian	- Intrace		Onest and Death	
NOIL	disease or condition resulting in death) Sequentielly list conditions,	Human		obacteni no deficioni no deficioni	um Aviam	- Infrace		Onest and Death	
ICATION	Sequentielly list conditions, if amy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR A	Myc s a consequence Fmmus as a consequence	CE OF):	um Avium Ency Viv.	- Intrace		Onest and Death	
RTIFICATION	disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR A	Myc As a consequence Fmmu	CE OF):	um Awam Ency Viv.	- Intrace		Onest and Death	
L CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	DUE TO (OR A	Myc As a consequence As a consequence As a consequence	CE OF):	/		Ilular	Onset and Death	
1	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR A	Myc As a consequence As a consequence As a consequence	CE OF):	/	Pert I. 24e. WAS AN	AUTOPSY IMED?	Onset and Death UMS 24b. WERE AUTOPSY FINDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE	
MEDICAL CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other significent conditions	OUE TO (OR A	Myc As a consequence	E OF):	lying cause given in	Pert I. 24e. WAS AN	AUTOPSY IMED?	Onset and Death C Mrs 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO	
MEDICAL	Sequentially ilst conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other significent conditions DID TOBACCO USE CONTRI	OUE TO (OR A	Myc As a consequence As	YES NO	lying cause given in	Pert I. 24e. WAS AN PERFO!	AUTOPSY IMED?	Onset and Death UMS 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
SICIAN: MEDICAL	Sequentielly list conditions, if amy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other significent conditions DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OUE TO (OR A	AS A CONSEQUENCE AS A CONSEQUENCE AS A CONSEQUENCE The but not result! OF DEATH 26. PLACE OF 1	YES NO DEATH (Check only OTHER:	lying cause given in UNCERTAIN	Pert I. 24e. WAS AN PERFO!	AUTOPSY IMED?	Onset and Death UMS 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
MEDICAL	Sequentielly list conditions, if arry, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other significent conditions DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNIFI OF DEATH	OUE TO (OR A CONTRIBUTE TO CAUSE HOSPITAL:	AS A CONSEQUENCE AS A C	YES NO DEATH (Check only OTHER: 4 Nursing	lying cause given in	Pert I. 24e. WAS AN PERFO!	AUTOPSY MED?	Onset and Death 2	
BY PHYSICIAN: MEDICAL	Sequentielly ilst conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other significent conditions DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNIFR OF OEATH 1 Netural 5 Pending investigation	DUE TO (OR A OUE TO (OR A OUE TO (OR A Contributing to deet	Myc Is a consequence As	YES NO DEATH (Check only OTHER: DA 4 Nursing TIME OF INJURY M 1	UNCERTAIN One) Home 5 Plasidenca INJURY AT WORK? YES 2 NO	Pert I. 24e. WAS AN PERFO! 1 VES 2 6 Other (Specify) 28d. DESCRIBE HOW I	AUTOPSY IMED?	Onset and Death C M-8 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
ED BY PHYSICIAN: MEDICAL	Sequentielly ilst conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other significent conditions DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNIER OF OEATH 1 Netural 5 Pending	DUE TO (OR A OUE TO (OR A OUE TO (OR A Contributing to deet	AS A CONSEQUENCE AS A CONSEQU	YES NO DEATH (Check only OTHER: DA 4 Nursing TIME OF INJURY M 1	UNCERTAIN One) Home 5 Plasidenca INJURY AT WORK? YES 2 NO	Pert I. 24e. WAS AN PERFO! 1 YES 2	AUTOPSY IMED?	Onset and Death C M-8 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
ETED BY PHYSICIAN: MEDICAL	Sequentielly list conditions, if arry, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST DID TOBACCO USE CONTRIBUTED C	DUE TO (OR A OUE TO (OR A OU	AS A CONSEQUENCE AS A CONSEQU	YES NO DEATH (Check only OTHER: DA 4 Nursing TIME OF INJURY M 1 rm, street, fectory,	Iying cause given in UNCERTAIN DONE Home 5 Plasidence INJURY AT WORK? YES 2 NO Office	Part I. 24e. WAS AN PERFOI 1 VES 2 6 Other (Specify) 28d. DESCRIBE HOW I City or Town, State)	AUTOPSY BMED? NJURY OCCUPAND AND AND AND AND AND AND AND AND AND	Onset and Death C M's 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO RED	
ED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other significent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:	DUE TO (OR A OUE TO (OR A OU	AS A CONSEQUENCE AS A CONSEQU	YES NO DEATH (Check only OTHER: DA 4 Nursing TIME OF INJURY M 1 rm, street, fectory,	Iying cause given in UNCERTAIN DONE Home 5 Plasidence INJURY AT WORK? YES 2 NO Office	Part I. 24e. WAS AN PERFOI 1 VES 2 6 Other (Specify) 28d. DESCRIBE HOW I City or Town, State)	AUTOPSY BMED? NJURY OCCUPAND AND AND AND AND AND AND AND AND AND	Onset and Death C M's 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentielly ilst conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURS AND TITLE OF CERTIFIER	DUE TO (OR A OUE TO (OR A OU	AS A CONSEQUENCE AS A CONSEQU	YES NO DEATH (Check only OTHER: DA 4 Nursing TIME OF INJURY M 1 rm, street, factory, curred at the time, getion, in my opinio	Iying cause given in UNCERTAIN DONE Home 5 Plasidence INJURY AT WORK? YES 2 NO Office	Part I. 24e. WAS AN PERFOI 1 VES 2 1 VES 2 6 Other (Specify) 28d. DESCRIBE HOW I City or Town, State) to the cause(s) and mai time, data end place, an	AUTOPSY IMED? NJURY OCCU and Number or oner as stated of due to the o	Onset and Death C M's 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO RED	
E COMPLETED BY PHYSICIAN: MEDICAL	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF OEATH 1 Natural 5 Pending Investigation Investigation (Check only One) 2 MEDICAL EXAMINER: 290. SIGNATURS AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	DUE TO (OR A OUE TO (OR A OU	AS A CONSEQUENCE AS A CONSEQU	YES NO DEATH (Check only OTHER: DA 4 Nursing TIME OF INJURY M 1 rm, street, factory, curred at the time, getion, in my opinio	Iving cause given in UNCERTAIN One) Home 5 Rasidenca INJURY AT WORK? VES 2 NO office data and place, and due on, death occured at the	Part I. 24e. WAS AN PERFOI 1 VES 2 1 VES 2 6 Other (Specify) 28d. DESCRIBE HOW I City or Town, State) to the cause(s) and mai time, data end place, an	AUTOPSY IMED? AND NO NJURY OCCUPAND AND AND AND AND AND AND AND AND AND	Onset and Death C M's 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO RED Rural Route Number, Cause(s) end manner as stated.	



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OF VITAL RECORDS,	
DIVISION OF	

1 THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	1 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3	filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burlal, cremation, or removal.	IPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TENDING PHYS	TOR: After this c	after death with	28 is marked,
PITAL DR AT	RAL DIREC	72 hours	I: If item
THE HOS	THE FUNE	filed within	PORTAN

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAGMAR 7995 PULKKINFN JUNE 30. 6:50p.m. 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) SEPT. 30, 5 SEY 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 297-32-8663 1 - M 2 X F 80 FINLAND 1914 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DOCTORS COMMUNITY HOSPITAL DIRECTOR LANHAM-SEABROOK PRINCE GEORGE'S CO. RESIDENCE OF DECEDENT 10b. COUNTY THE CITY TOWN OR LOCATION 10d. INSIDE CITY MARYLAND PRINCE GEORGE LANHAM-SEABROOK 1 YES 2 NO 10e, STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7017 96TH AVENUE 20706 USA 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 WHO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married 1 YES 2 NO BY Specify Specify: WHITE 3 🕅 Widowed 4 🗌 Divorced COMPLETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only Elementary/Secondary (0-12) College (1-4 or 5+) COOK PRIVATE CLUB 17. FATHER'S NAME (First, Middle, Leat) 18. MOTHER'S NAME (First, Middle, Maiden Surname) UNAVAILABLE UNAVAILABLE BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 KENNETH PULKKINEN 7017 9TH AVENUE, LANHAM, MARYLAND 20706 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, Stata BALTIMORE-WASHINGTON CREM 7/2 LAUREL. MARYLAND IL SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MD 20707 23. PART I. Enter the diseases, or comp and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ehock, or heart failure. List Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) AUPITE 6 doil DUE TO (OR AS A CONSEQUENCE OF) laskyden. toon CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate 5011001100 ceuse. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other eignificant conditions contributing to deeth but not reaulting in the underlying cause given in Pert I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24s. WAS AN AUTOPSY Japa IV 1 TES 2 THO DF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 Pinpatient 2 ER/Outpatient 3 DOA 4 - Nursing Nome 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Yours, State) COMPLETED 8 Could not be 4 Homicide datermined 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) A + tend ix 220079 3) 7497 Exentive Pl. Avor Sealrost, no 20706

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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am , of woreldox Dan H.

JUL 0 7 1995

29b. SIGNATURE AND TITLE OF CERTIFIER

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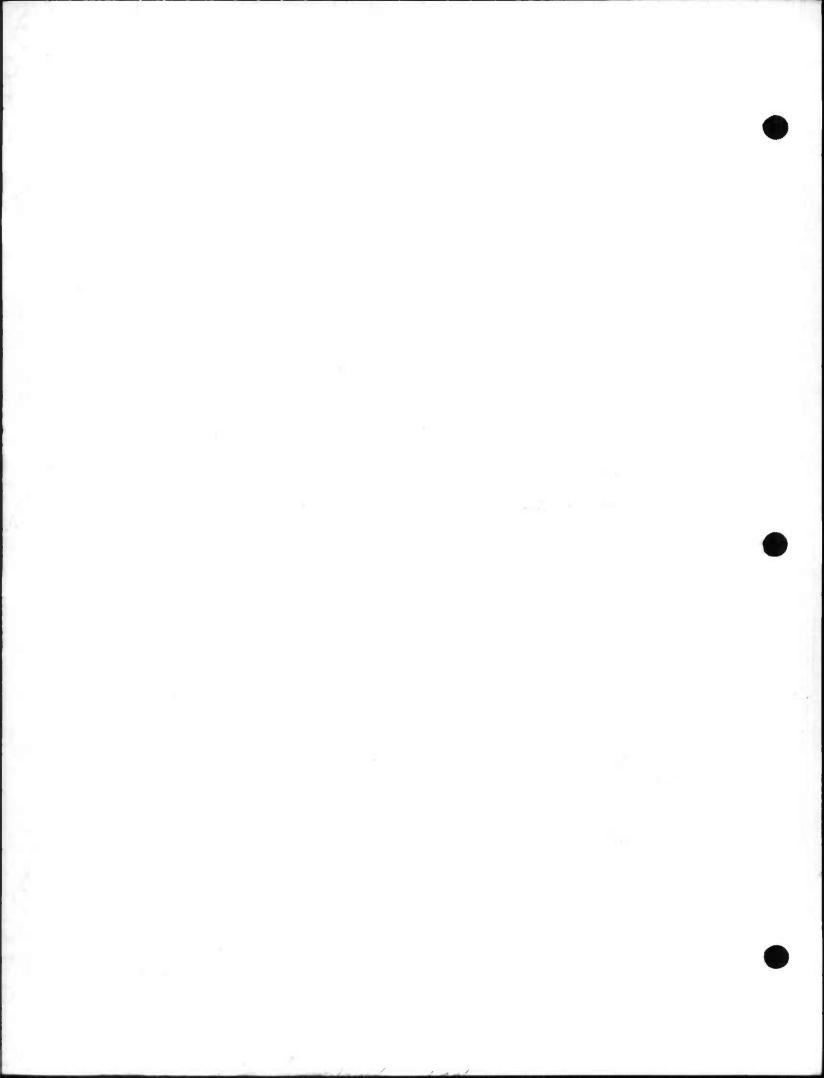
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit narmit pages 1 2 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examinar must be notified at once.

-3	REGISTRAR		CERTIFIC	CATE OF	DEATH	REG	. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEA	TH	3. TIME OF DEATN		
	Joseph Melville	Pembroke				June 3	0, 1995	5:45 A M		
	218-07-7313	16 M 2 □ F 8		F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRT (Month, Day, Ye April 9	, 1908 a.	BIRTHPLACE (State or Foreign Country) Maryland		
OR		96. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH Crofton Nursing Home Crofton Anne Aru								
5	RESIDENCE OF DECEDENT									
DIRECTOR	Maryland N/	A		rown or Location Baltimore				10d. INSIDE CITY LIMITS? 1 X YES 2 NO		
FUNERAL	100. STREET AND NUMBER 4786 Elison Avenu	e		101	2120	6	100	S. A.		
BY FUN	11. MARITAL STATUS 1: 1 Never Merried 2 M Merried 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT	U.S. ARMED 2 X NO TES	If yes, sp	ENDENT OF HISPAI ecity Cuben, Mexice 2 X NO Specifi	m, Puerto Rican, et	fy Yea or No.— 14. c.)	RACE — American Indian, Black, White, etc. Specify:		
TO BE COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor Elementary/Secondary (0-12)	mpleted)	16e. DECEDENT'S US (Give kind of wor life. Do NOT use i	BUAL OCCUPATION done during mo	ON est of working	16b. KIND O	F BUSINESS/INDUS			
	N/A 17. FATNER'S NAME (First, Middle, Last)	College (1-4 or 5 +)	Route Sux		r			ck Company		
	John H. Pembroke					ME (First, Middle, M	_{eiden Sumame)} Trossbac	h		
	19a. INFORMANT'S NAME (Type/Print) Helen Meagher (Nie	col					or Town, State, Zip Co Marylan			
2	20a. METHOD OF DISPOSITION	206.8	PLACE AND DATE OF	DISPOSITION (Na	me of	OATE 20	c. LOCATION — City	or Town, State		
	1X Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other/Specify 4 Donation 5 Other/Specify 23 NAME AND ADDRESS OF FACULTY 23 NAME AND ADDRESS OF FACULTY 23 NAME AND ADDRESS OF FACULTY									
	Min 2 pe	Schimunek Funeral Home								
	23 PART I. Enter the diseases or com shock, or heart failure. Lis	aplications that caused tonly one cause on ee	the death. Do not	enter the mo	de of dying, suc	h aa cardiac or	respiratory arrest	Approximate interval Batween		
- 1	IMMEDIATE CAUSE (Final							Onset and Death		
	resulting in death) a. Congestive Heart Failure OUE TO (OR AS A CONSEQUENCE OF):									
NO	Coronary Atherosclerosis									
CATI	Sequentiesly list conditions, if any, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that inlitted events Due to (or as a consequence of): Due to (or as a consequence of):									
CERTIFICATION	that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Carcinoma of Kidney, Bladder and Colon							3/93		
AL C	PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY FINDINGS									
EDICAL	Atrial Fibrillation Performed?							AMBLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
Σ	Newrogenic Dysphagia									
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: QTHER:									
IYS	1 YES 2 NO 1	□ Inpatient 2 □ ER/Outpat 28s. DATE OF INJURY	tient 3 DOA 4	Nursing Hom	e 5 Residence					
ВУ Р	1 Netural 5 Pending Investigation	(Month, Day, Year)	28b. TIME C INJUR	Y WO	URY AT RK? 'ES 2 NO	28d. DESCRIBE N	OW INJURY OCCUR	ED		
	2 Accident 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Yown, State)						itural Floute Number,			
COMPLETED		N: To the best of my knowled on the basis of examination						euse(s) and menner as stated.		
BE C	290 SIGNATURE AND TITLE OF CERTIFIER	α	001		29c. LICENSE NUN			GNED (Month, Dgy, Yber)		
TO 8	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEATH	IN CITEM 27 COLO		D20	108	16	130/95		
	Dr. Rakesh Arora	, 14300 Gall	lant Fox		Suite 222	2, Bowie	, Marulai	nd 20715		
	JUL 0 71995 Jul	32. TEGISTRAR'S SICHAT	254				-/-			



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR **CERTIFICATE OF DEATH** 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH MONTH 3. TIME OF DEATH PLEYO VIOLA BLANCHE 1:45 995 Pм JULY 03 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH
(Month, Day, Ybar)
Jan. 29, 1926 8. BIRTHPLACE (State or Foreign 213-22-1317 69 DAYS 1 M 2 X F YRS. Pennsylvania Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Gambrills MD.RTE.175 & OAKTON ROAD ANNE ARUNDEL RESIDENCE OF DECEDENT Anne Arundel 10a. STATE Odenton 10d. INSIDE CITY 1 X YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 21113 10g. CITIZEN OF WHAT COUNTRY? 326 Nevada Avenue and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit o burial, cremation, or removal. retained by the hospital or attending physician. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yea, specify Cuban, Maxican, Puarto Rican, etc.)
1 ☐ YES 2 ☑ NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married Specify: White BY 3 € Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 8 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname Patrick Haggerty Minnie Cribbs notified at 品 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 5607 Harbour Valley Drive, BAltimore, 2MD Patrick J. Pleyo Раде 6 тау be pe 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Maryland National Mem.Pk.7 ☐ Donation 5 ☐ Other (Specify) Laurel, MD 21. SIGNATURE OF FUNERAL SURVIVE LICENSES examiner 22. NAME AND ADDRESS OF FACILITY hours after death. Hardesty Funeal Home, P.A. 12 Ridely Ave. Annapolis, MD 21401 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata ahock, or heart failure. List only one cause on each line. Interval Batween 6 **IMMEDIATE CAUSE (Finel Onset and Death** the disease or condition MULTIPLE INURNES event, reaulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): the attending physician a Mental Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): thet initieted events resulting in death) LAST 6 PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? signed by the that any 1 YES 2 NO OF DEATH? 1 TYES 2 T NO t. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: WE has be 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) The certificate I EXAMINER? L OR ATTENDING PHYSICIAN: The DIRECTOR: Atter this certificate it hours after death with the State HOSPITAL OTHER: 1- YES 2 NO 1 Inpetiant 2 I ER/Outpetient 3 I DOA EXPorther (Specify) SCENE OF ACCIDENT 4 - Nursing Home 5 - Rasidence 10 27, MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) this c 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 🔲 jilatural 95 DRIVER OF CAR STRUCK BY 13441" 1 YES 2 THO BY 2 Accident 28e. PLACE OF INJURY — At home, term, street, tactory, offica building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town State) 8 Could not be COMPLETED 4 Homicide ODDWAY RT 175 DOUND ANDOL 29a, CERTIFIER 1 ___ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) TO THE HOSPITAL
TO THE FUNERAL I
DE filed within 72 h
IMPORTANT: If II 2 MEDICAL EXAMINER: On the beals of exc vestigation, in my opinion, death occured at the time, data and place, and due to the ceuse(a) and manner as stated. 29d. DATE SIGNED (Month, Day, Year 29c. LICENSE NUMBER BE JULY 04,1995 une O.C.M.E. 2 LETED CAUSE OF DEATH (ITEM 27) (Type, Print) MO111 Penn Street, Baltimore, Maryland 21201

DHMH-16 Rev 1/89

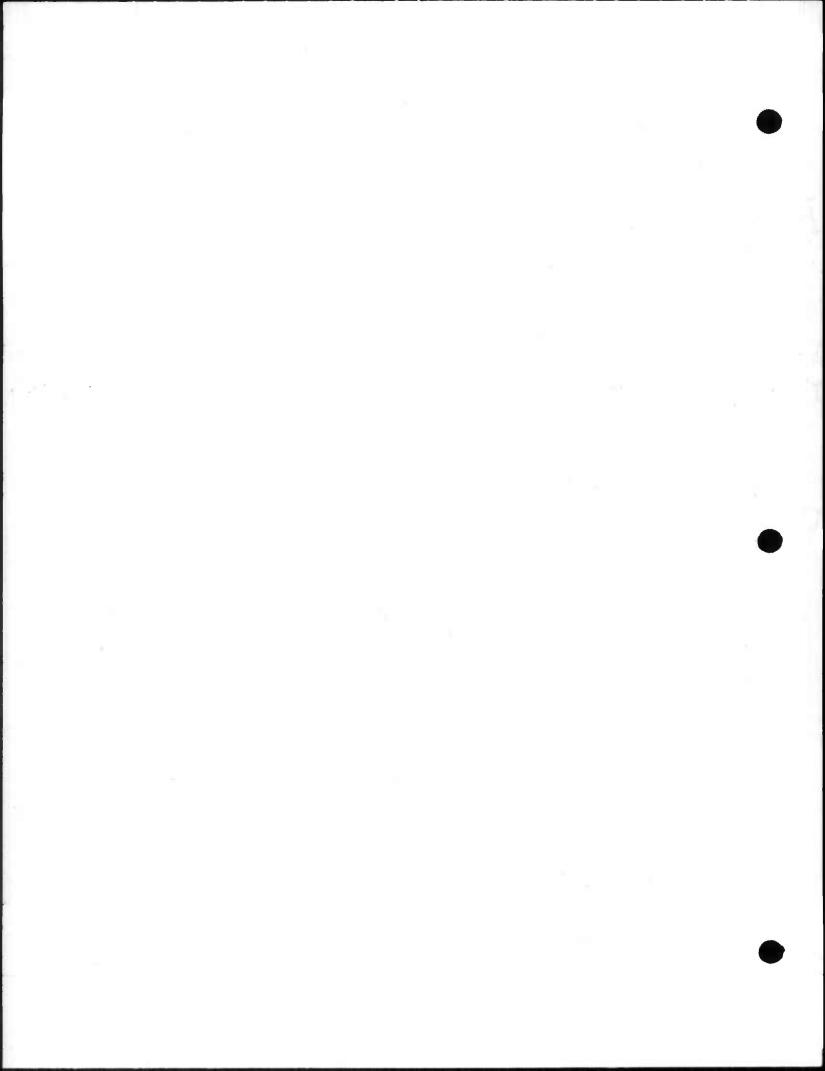
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	REGISTRAR		CERTII	FICATE OF	DEATH	REG. NO						
	1. DECEDENT'S NAME (First, Middle	, Lest)					2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF					
	Daryl	S		Reedy			199	5 2150 M				
9	4. SOCIAL SECURITY NUMBER		AGE (In yrs. lest birthday,		IF UNDER 24 HRS.	July 04		BIRTHPLACE (State or Foreign				
j	190 44 1535	1 🖾 M 2 🗆 F	26 YRS.	MONTHS DAYS	HOURS MIN.	09 29 68		Pennsylvania				
	9a. FACILITY NAME (If not institution	, give street and number)		9b. CITY, TOWN	OR LOCATION OF D		9c. COUNTY					
E C	1		. 1									
K	Falston Gene	eral Hospit	aı	Falls	ton		<u>H</u>	arford				
38		COUNTY	10c. CI	TY, TOWN OR LOCA	TION			10d. INSIDE CITY				
DIRECTOR	Pa.	York		York				1 YES 2 NO				
	10e. STREET AND NUMBER			10	H. ZIP CODE		10a, CITIZEN	OF WHAT COUNTRY?				
FUNERAL	333 Westwoo	od Drive		1	7404		USA					
5	11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. ARMED	13. WAS DE	CENDENT OF HISPAI	NIC ORIGIN? (Specify Ye	or No. 14	RACE — American Indian,				
	1 Never Married 2 Marrie	FORCES? 1 IF YES, GIVE WAR		If yes, s	pecify Cuban, Maxica	in, Puerto Rican, atc.)		Black, White, atc.				
ΒX	3 Widowed 4 Divorced		on onles	'''	B 2 NO Specif	γ.		White				
<u> </u>	15. DECEDENT (Specify only highes	'S EDUCATION	16a. DECEDENT	S USUAL OCCUPAT	ION	16b. KIND OF BU						
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5+)		work done during muse retired.)	ost of working	Charl	c D					
4		1	Truck	Driver		State	or Pe	nnsylvania				
COMPLETED	17. FATHER'S NAME (First, Middle, L.	nst)			16. MOTHER'S NA	ME (First, Middle, Maiden	Surname)					
BE	James G. Re	eedy			Glori	a Emig		3				
	19a, INFORMANT'S NAME (Type/Prin		19b. MAILIN	O ADDRESS (Street		Route Number, City or Tow	n. State. Zio Coi	de)				
임	Melissa Rec	edy				ork, Pa. 17						
	20a. METHOD OF DISPOSITION		20b. PLACE AND DATE					or Town, Stata				
- 1	1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		cemetery, crematory or		7.0	1_	er,Pa.	or rown, orace				
	21. SIGNATURE OF FUNERAL SERV	ICE LICENSEE	ROTILCE		<u> </u>							
	D Charles	b Bule	parame	Charl	es S. Ze	iler & Son	Inc.					
-	Oppose	, J.				ing St. Ba						
	23. PART I. Enter the disease shock, or heart fa	ii, or complicatione that ci liure. List only one ceuse	oused the deeth. Do on each line.	not enter the me	ode of dying, suc	h as cerdiec or reep	ratory arrest	Approximate interval Batween				
	IMMEDIATE CAUSE (Finel			4 4				Onset and Death				
ļ	disease or condition resulting in death)	. Mult	yle In	i walls								
	resulting in death) a. Multiple by Ries DUE TO (OR AS A CONSEQUENCE OF):											
z I	Sequentially list conditions	Samuellalle, Van and Valar Ch.										
Ĕ	if any, leading to immediate											
2	cause. Enter UNDERLYING CAUSE (Disesse or Injury	c										
	thet initiated events resulting in deeth) LAST	DUE TO (OR	AS A CONSEQUENCE O	OF):								
CERTIFICATION	Todaking in addit, End	d										
	PART ii. Other significent con	ditione contributing to de	eth but not resulting	in the underlyin	a ceuse given in	Part i. 24s. WAS AN	ALITOPSY	24b. WERE AUTOPSY FINDINGS				
CAL			-	,	g	PERFOR	MEO?	AMILABLE PRIOR TO COMPLETION OF CAUSE				
						1 YES 2	□ NO	OF DEATH?				
Σ	DID TORACCO LISE CO	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
ĕ ∥	25. WAS CASE REFERRED TO MEON			ATH (Check only one)		<u> </u>		``				
3	EXAMINER? 1 2 YES 2 NO	HOSPITAL: X		OTHER:								
n II	27. MANNER OF OEATH	1 ☐ Inpetient 2 € EF			ne 5 🗆 Rasidenca							
<u></u>		(Month, Day,)		JURY W	JURY AT ORK?	28d. OESCRIBE HOW I	NJURY OCCUR	a clist other of				
PHYSICIAN:			7	0 a M 1 L	YES 2 NO	1 - 1.	1.01					
BY PHY	1 Natural 5 Pending	atlon 7149	3 (74		04	venue	6				
5	1 Netural 5 Pending 2 Assident Investig 3 Suicide 6 Could in	ation 7/49 28e. PLACE OF IN building, etc.	JURY — At home, farm, (Specify)	74	:•	281. LOCATION (Street (City or Town, State)	and Number or F	tural Route Number,				
5	1 Netural 5 Pending 2 Accident Investig 3 Suicide 6 Could r 4 Homicide determine	ation 7/49 28e. PLACE OF IN building, etc.	(Specify)	74	. 1	281. LOCATION (Street of City or Town, State)	and Number or F	Eural Route Number, Hentard				
5	1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 Could r determi 29a. CERTIFIER (Check only	ation ation 28e. PLACE OF IN building, etc. PHYSICIAN: To the best of my	knowledge, death occur	street, factory, office	and place, end dua	City or Town, State)	mer as eletely	Herford manyland				
5	1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 Could r determi 29a. CERTIFIER (Check only	ation 7 4 4 9 1 28e. PLACE OF IN building, etc.	knowledge, death occur	street, factory, office	and place, end dua	City or Town, State)	mer as eletely	Herford manyland				
COMPLEIED BY	1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 Could r determi 29a. CERTIFIER (Check only	ation 28e. PLACE OF IN building, etc. PHYSICIAN: To the best of my AMINER: On the basis of exami	knowledge, death occur	street, factory, office	and place, end dua	to the cause(a) and mar	mer as elected d due to the ca	Herford Manyland Juse(a) and manner sa stated.				
BE COMPLETED BY	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. CERTIFIER (Check only one) 2 MEDICAL EX	ation 28e. PLACE OF IN building, etc. PHYSICIAN: To the best of my AMINER: On the basis of exami	knowledge, death occur	street, factory, office	and place, and dua death occurred at the 29c. LICENSE NUM	to the cause(a) and mar time, data end place, en	mer as settled, d due to the ca	Herford Manyland use(a) and manner as stated. GNED (Month, Day, Year)				
COMPLEIED BY	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. CERTIFIER (Check only one) 2 MEDICAL EX	ation ot be lot of my AMINER: On the besis of examination of the lot be lot of the lot be lot of lot	knowledge, death occur	street, factory, office	and place, end dua leath occured at the	to the cause(a) and mar time, data end place, en	mer as elected d due to the ca	Herford Manyland use(s) and manner as stated. GNED (Month, Day, Year)				
DE COMPLETED BY	1 Natural 5 Pending Investig 1 Investig 2 Accident 3 Suicide 4 Homicide 6 Could referral 29e. CERTIFIER (Check only one) 2 MEDICAL EX 29e. BIGNATUSE AND TITLE OF CES	ation ot be lot of my AMINER: On the besis of examination of the lot be lot of the lot be lot of lot	knowledge, death occur nation and/or investigati	street, factory, office	e and place, and due death occured at the 29c. LICENSE NUM	City or Town, State) Carco A to the cause(a) and mar time, data end place, en	d dua to the ca	Herford Manyland use(a) and manner as stated. SNED (Month, Day, Year) Ly 05 1995				
DE COMPLETED BY	1 Natural 5 Pending Investig 1 Investig 2 Accident 3 Suicide 4 Homicide 6 Could referral 29e. CERTIFIER (Check only one) 2 MEDICAL EX 29e. BIGNATUSE AND TITLE OF CES	physician: To the best of my AMINER: On the basis of exami	knowledge, death occur nation and/or investigati	street, factory, office	e and place, and due death occured at the 29c. LICENSE NUM	City or Town, State) Carco A to the cause(a) and mar time, data end place, en	d dua to the ca	Herford Manyland use(a) and manner as stated. GNED (Month, Day, Year)				



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		1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF		MENTAL HYGI REG.				
		1. DECEDENT'S NAME (First, Middle, Last)	CF Robert	Andrew F	Ruff Jr.		2. DATE OF DEATH	DAY 1	VEAD 1	TIME OF DEATH	M
79		4. SOCIAL SECURITY NUMBER 215–14–9848	1 X M 2 □ F 72	(In yra. last birthday) YRS.	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH	, 1923 N	Country)	and	
2, 3 should	OR	9a. FACILITY NAME (If not institution, give s St. Agnes Hospita RESIDENCE OF DECEDENT			Baltim	or location of d		9c. COUNTY		Н	
permit. Pages 1,	DIRECTOR	10a. STATE 10b. COUNTY Maryland Baltin		10c. CIT	Y, TOWN OR LOCA	Catonsv	ille			d. INSIDE CITY LIMITS? VES 2 X NO	=
1St	FUNERAL	10a. STREET AND NUMBER 406 Harwood Road			10	01. ZIP CODE 21228				T COUNTRY?	
215-0020 attending physician. se as the burial-transit	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 X YES IF YES, GIVE WAR OR D	2 NO	If yes, s		NIC ORIGIN? (Specify an, Puerto Rican, etc.) fy:	Yes or No- 14	I. RACE — Black, W	American Indien, Inite, atc.	-
2 2 2	APLETED	15. DECEDENT'S EDUI (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+) 4	16a. DECEDENT'S (Give kind of life. Do NOT un Insurance	<i>'</i>	ost of working		BUSINESS/INDUS	STRY	nge Firm	
SYLAND of the hospital of the detached for the detached f	BE COMPL	17. FATHER'S NAME (First, Middle, Last) Robert Andre	ew Ruff, Sr.				AME (First, Middle, Mei Louise El	den Surname)			
RE, MAR ay be retained I page 5 should be notified	10	190. INFORMANT'S NAME (Type/Print) Elizabeth B. Ruff					Route Number, City or SVIlle, M		xde)		
ALTIMORE death. Page 6 may e tuneral director, page it.		20a. METHOD OF DISPOSITION 1 № Burial 2 □ Cremation 3 □ Rame 4 □ Donation 5 □ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC	oval from Stata	PLACE AND DATE	enetery	07/07/	/95	Chester			
BALTIMORE after death. Page 6 may by the funeral director, pa moval. cal examiner must to		Dawn 7. mg	2 Donald	1cDonald	MacNa 301 F:	bb Funera rederick	Home, Rd. Balt	P.A. imore, 1	MD 21	1228	
within 24 hours pletely filled in b cremation, or referr, the medi		23. PART i. Entar the diseases, or cahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a.	ach iina.		My f		apiratory arrea	t,	Approximate interval Batween Onset and Daeth	
OX 68 be execute clan and cl ior to buria	CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A	A CONSEQUENCE OF		/					
P.O. th certific ending p r Hygiene or othe	CERTIFI	that initiated events resulting in death) LAST	DUE TO (OR AS A	A CONSEQUENCE OF	F):						
L RECORD: law requires that the iss been signed by th ept. of Heaith and N 23 shows any inj	MEDICAL	PART II. Other significant condition CONOMALY CWOM'C DID TOBACCO USE CONTR	remail RIBUTE TO CAUSE O	OLISCAS(FOU'LU'V F DEATH YE	e/ s 🗆 no [UNCERTAI	1 TYES	AN AUTOPSY FORMED?	CO OF	ALLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO	
B B B TA	YSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:		OTHER: 4 - Nursing Hor	ne 5 🗆 Residence	8 Other (Specify)				
ATENDING PHYSICIAN: ECTOR: After this certifica s after death with the St. 128 is marked, or it.	ВУ РНУ	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)		M 1	JURY AT ORK? YES 2 NO	28d. DESCRIBE HO				
DIVISIC DR ATTEND DIRECTOR: A hours after d item 28 is	LETED	3 Suicide a Could not be datermined	building, etc. (Spec	cify)			281. LOCATION (Stre City or Town, St.	efe)	Huraf Rouli	Number,	
로 그 드 트	COMPLET	(Check only one) 1 CERTIFYING PHYSIC One) 2 MEDICAL EXAMINE	CIAN: To the best of my know						ause(a) an	d menner as stated.	
TO THE HOSPIT TO THE FUNERS be filed within 7	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	you M	D,	Print)	DO _	2062.	29d. DATE S	IGNED (MO	4, 1995	
5		SAMIH JAR: 31. DATE FILED (MONTH), Day, Year)	JOUR M.D.	ST. ACH		SP., 900	CATON +	WE, E	3A-L	FIMORE	
		JUL 07 1905	Julia Davide	or Kardall	****					DHMH-16 Rev 1/8	

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	L HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTA	IENT OF HEALTH ATE OF DEAT	AND ME	ENTAL HYGIENI REG. NO.	Ē				
1	1. DECEDENT'S NAME (First, Middle, Last)	011				DATE OF DEATH		3. TIME OF DEATH			
	ATHA FLORENCE	E REY			-	TOLY 6	(6.6	\$ 435Am "			
	4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (fi		UNDER 1 YEAR IF UNDER		DATE OF BIRTH	8.	BIRTHPLACE (State or Foreign			
	219-03-7995 1 M 2 K F 75 YRS. MONTHS DAYS HOURS MIN. 98. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF D						Country Country Country Maryland Sc. COUNTY OF DEATH				
DIRECTOR	STELLA MARIS HOSP			TOWSON				ALTIMORE			
3EC	10s. STATE 10b. COUNTY		10c. CITY, T	OWN OR LOCATION				10d. INSIDE CITY			
	MARYLAND	BALTIMORE	B	AYNESVILLE				1 YES 2 NO			
FUNERAL	10e. STREET AND NUMBER			10f. ZIP CODE			10g. CITIZEI	N OF WHAT COUNTRY?			
ħ.	8503 WILLOW OAK RO	DAC		21	.234		1	USA			
5	11. MARITAL STATUS 12 1 Never Married 2 Married	P. WAS DECEDENT EVER IN FORCES? 1 YES		13. WAS DECENDENT O			or No- 14	. RACE American Indian, Black, White, etc.			
B	3 XWidowed 4 Divorced	IF YES, GIVE WAR OR DA		1 TES 2 NO		,		Specify:			
	15. DECEDENT'S EDUCAT	ION I	18a. DECEDENT'S US	IAL OCCUPATION		16b. KIND OF BUS	INESS/INDIES	WHITE			
ET	(Specify only highest grade con	npleted) College (1-4 or 5+)	(Give kind of work life. Do NOT use re	done during most of working	g	No. KIND OF BOS	INC33/IND03	'''			
PL	10th GRADE	onege (I-4 of 3 +)	CASHIER			A	& P				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			18. MOTI	IER'S NAME	(First, Middle, Maiden S					
BE C	CHARLES STOTTLEMYE	R			MIG	NON CARSO	N				
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street and Number	or Rural Rout	te Number, City or Town	, State, Zip Co	ide)			
F	DONALD REY		9819 н	ICKORYHURSI	DRIV	E BALTIM	ORE, I	MD 21236			
	20s. METHOD OF DISPOSITION 1X Burlal 2 ☐ Cremation 3 ☐ Removal	from State 20b.	PLACE AND DATE OF D	ISPOSITION (Name of		DATE 20c. LOC	ATION — City	y or Town, State			
	4 Donation 5 Other (Specify)	M		EMORIAL PAF			ILLEN	DALE, MD			
	21. SIGNATURE OF FUNERAL SERVICE LICENS	HEE.		JOHNSON E							
	1//		3	8521 LOCE	RAVE	N BLVD.	TOWSO	N, MD 21286			
	28. PART i. Enter the diseases, or com spock, or heart feilure. Lie	plicatione that caused	the death. Do not	enter tha mode of dy	ng, auch e	s cerdiec or reepir	atory srrest				
	IMMEDIATE CAUSE (Finel										
	disease or condition resulting in death) a. OVARIAN CANCER 2475,										
	DUE TO (OR AS A CONSEQUENCE OF):										
No.	Sequentielly list conditions, Due to (OR AS A CONSEQUENCE OF):										
Ě	csuse. Enter UNDERLYING										
三	CAUSE (Diseeee or Injury thet initisted events	thet initisted events DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	resulting in deeth) LAST										
	PART II. Other significent conditions c	ontributing to death by	it not reculting in t	ha undariuing acusa	duan in Da	rt i. 24a, WAS AN A					
CAL	The state of the s	onlineding to deeth be	it not resulting in t	ne underlying cause (liven in Per	PERFORI	WED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE			
ED						1 TYES 2	NO	OF DEATH?			
Σ.	DID TOBACCO USE CONTRIB	LITE TO CALISE OF	DEATH VEC		ERTAIN	-		1 TYES ZX NO			
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL		6. PLACE OF DEATH		EKIAIN	A					
SIC		OSPITAL:	0	HER: Nursing Home 5 Re	eldanes B [Outra (Caralla)					
H	27. MANNER OF DEATH	28a. DATE OF INJURY	26b. TIME O	28c. INJURY AT		d. DESCRIBE HOW IN	JURY OCCUR	RED			
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	M 1 YES 2	NO						
	3 Suicide 8 Could not be	28e. PLACE OF INJURY building, atc. (Speci	Al home, farm, atree	t, factory, office	26	31. LOCATION (Street at	nd Number or	Rural Route Number,			
H	4 Homicide determined	Landing that joposi				City or Town, State)					
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSICIAL	N: To the best of my knowle	edge, death occurred a	t the time, date and place,	and due to	the cause(s) and mans	ter as stated.				
O								ause(a) and manner as stated.			
	296. SIGNATURE AND TITLE DF CERTIFIER	0 0		290 LICE	NSE NUMBE	R	29d. DATE SI	IGNED (Month, Day, Year)			
O BE	Prendall K	-aux leu	euro	10	256	43	► 7/(0/95			
2	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, Prin	RA/BO	elfo	NO a	204	1			
	31. DATE FILED (Month Day Year)	32 REGISTRAR'S SIGNA	TURE	8							
	JUL 0 7 1995 July	WILLIAM TON	Tall-								

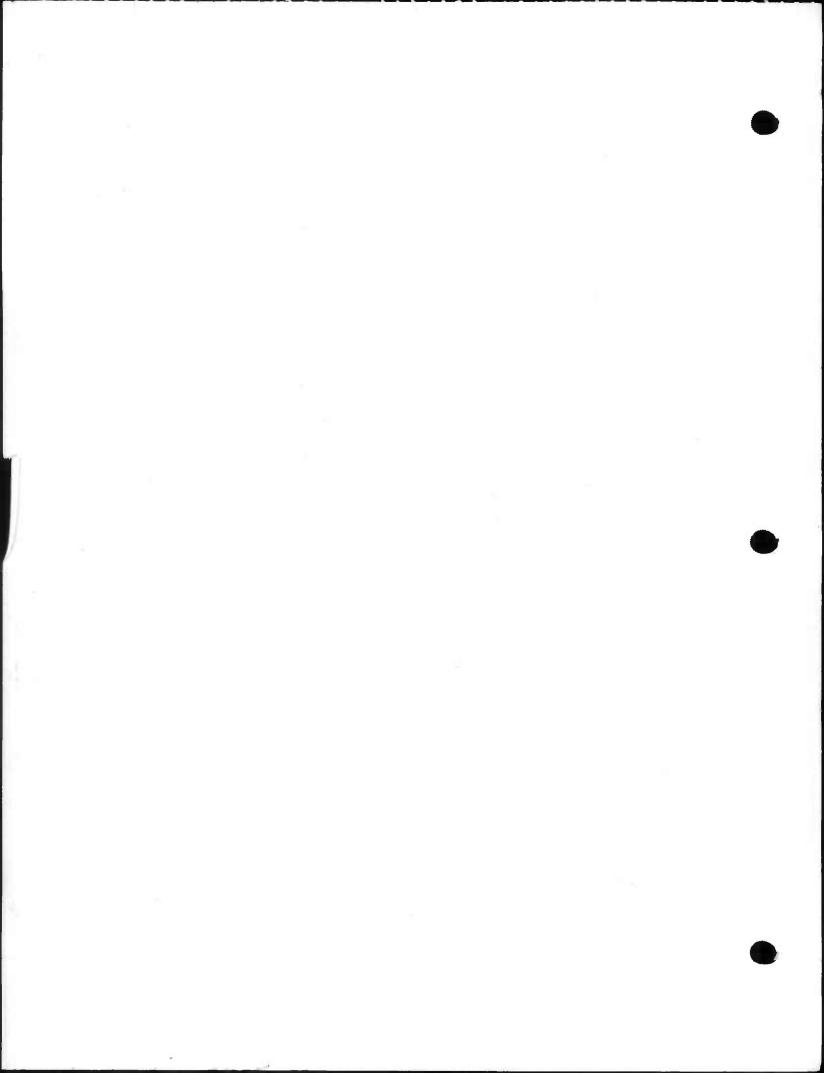


attending physician. use as the burial-transit permit. Pages 1, 2. 3 should BALTIMORE, MARYLAND 21215-0020

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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the luneral director, page 5 should be detached for up be filled within 27 burs after detach with the State Dept. of Health and Mental Hyplenes pitch in burst, or prefer the most of the marked or Heart 28 shows and Interv. or other Hamman to see the marked or lister 25 shows and Interv. or other Hamman to see the marked or lister 25 shows and Interv. or other Hamman to see the marked or lister 25 shows and Interv. or other Hamman to see the marked or lister 25 shows and Interv. or other Hamman to see the marked or see the marked or lister 25 shows and Interv. Or other Hamman to see the marked or lister 25 shows and Interv.

	1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTAL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	V VE	3. TIME OF DEATH	
	Luther Edward Ro					July 2,			
			n yrs. last birthday) 71 Yns.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Feb. 18,19	124 P	NATHPLACE (State or Foreign country)	
	9a. FACILITY NAME (If not institution, give stre	et and number)		9b. CITY, TOWN C	PR LOCATION OF D				
DIRECTOR	Meridian Nursing	То	wson		Bal	timore			
HE	10a. STATE 10b. COUNTY	10c, CITY	TOWH OR LOCAT	TION			10d. INSIDE CITY LIMITS?		
	Maryland Ba	ltimore			imore			1 TYES 2 NO	
FUNERAL	4222 E. Joppa Ro	ad		106	21236			OF WHAT COUNTRY?	
NO.	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 X YES	U.S. ARMED			NIC ORIGIN? (Specify Yes	or No- 14. I	RACE — American Indian,	
ВУ	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DA	TES		2 NO Specif	an, Puarto Rican, atc.) ly:		Black, White, etc. Specify: White	
	15. DECEDENT'S EDUCA (Specify only highest grade of	TION	18a. DECEDENT'S U	SUAL OCCUPATION	DN .	18b. KIND OF BUS	INESS/INDUSTI		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use		st of working	Ctoo	0 0		
)MP	9th grade 17. FATHER'S NAME (First, Middle, Lest)		Steelwo	reel	40 1407115010 111		l Compa	iny	
BE CO	Willard Rous	h				M. Dimm	Sumame)		
TO B	19a, INFORMANT'S NAME (Type/Print) Hazel L. Roush	lusi (a)				Route Number, City or Town			
	20a, METHOD OF DISPOSITION	(wife)	PLACE AND DATE O			Baltimore	, MU 2	21236	
	1 ABurial 2 Cremation 3 Ramov 4 Donation 5 Other (Specify)	ni from Stata	reland M	emorial	Park			Maryland	
	21. SIGNATURE OF FUNERAL SERVICE LIDER	esee 1		SChim	ID ADDRESS OF FA	ieral Homes	Tuc		
	- Kopy Marga	my		9705	Belair R	d. Baltim	ore. MI	21236	
NOI	23. PART I. Enter the diseases, or complications, thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
MEDICAL	PART II. Other eigniticent conditions contributing to death but not resulting in the underlying cause given in Part i. 24e. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO								
	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	F DEATH YES	NO [UNCERTAI	N/KI			
PHYSICIAN:		IOSPITAL:		OTHER:					
HYS	1 YES 2 NO 1	☐ Inpatiant 2 ☐ ER/Output 28a. DATE OF INJURY	Itlant 3 DOA			6 Other (Specify) 28d. DESCRIBE HOW II	LIURY OCCURE	n	
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU	RY WO	RK? ES 2 NO		OCCUPACION CONTRACTOR OF THE C	·	
	3 Suictde 8 Could not be datarmined	26s. PLACE OF INJURY building, etc. (Speci	— At home, farm, st	reet, factory, office		28t, LOCATION (Street and Number or Rural Route Number, City or Town, State)			
COMPLET	29a. CERTIFIER (Check only	N: To the best of my knowle	edge, death occurred	at the time, data	and place, and due	to the cause(a) and man	ner sa stated.		
OM	one) 2 MEDICAL EXAMINER:	On the basis of exemination	and/or investigation	, in my opinion, de	eath occured at the	time, date and placa, and	due to the cau	se(a) and manner as stated.	
BE C	29h. SIGNATUHE AND JITLE OF CERTIFIER				29c. LICENSE NUI	MBER .	29d. DATE SIG	NED (Month, Day, Year)	
5	30 MAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) /7ma	Print)	D41	901	7	7/5/90	
	BUS FWILS	a'WD' 3	5007 E	Nov	en Pa	My Bo	eltre	M7 51516	
- 0	JUL 0 71995	32. REGISTRAR'S SIGNA							



FOR STATE REGISTRAR

RICHARD

4. SOCIAL SECURITY NUMBER

237-50-0455

1. DECEDENT'S NAME (First, Middle, Last)

BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	
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Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 2000 BLK. ODELL AVE. BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND n/a BALTIMORE permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE APT. 21237 2000 ODELL **AVENUE** burial-transit Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married
3 Widowed 4 Divorced BΥ 1 - YES 2 - NO Specify: the funeral director, page 5 should be detached for use as the n/a COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) VARIOUS Elementary/Secondary (0-12) College (1-4 or 5+) LABORER STATE of 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme J0E RANDOLPH SR. MARTHA notified at 띪 190. INFORMANT'S NAME (Type/Print)
JANET QUEEN 196 MAILING ADDRESS (Street and Number of Avenue, House, BALT IMORE, MARYLAND 9 9 20s, METHOD OF DISPOSITION

1 Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must COMESTEAD CEMETERY Donation 5 Other (Specify) 7-6 medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, and completely filled in by burial, cremation, or remo shock, or heert failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final the disease or condition CAGOLOVARCULAR ATHOMOS CUE PLOTIC resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to if any, leeding to immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior to other t CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa reaulting in death) LAST 5 injury, PART II. Other algnificant conditions contributing to deeth but not reculting in the underlying cause given in Part I. MEDICAL 23 shows any been s DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be Dept. 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL Пеш EXAMINER? certificate State HOSPITAL: OTHER: TX YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA ng Home 5 ☐ Residence 6X Other (Specify) IN VEHICLE the 0 27. MANNER OF DEATH 28e. DATE OF INJURY marked, with t 26b. TIME OF INJURY 28c. INJURY AT WORK? 1 Natural Pending investigation м 1 YES 2 NO DIRECTOR: After the hours after death was В 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office 99 3 Suicide 6 Could not be COMPLETED 28 4 Homicide 29e. CERTIFIER 1 ___ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner as stated. TO THE HOSPITAL OF THE FUNERAL D BE filed within 72 ho 2 💢 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end manner ee stated. 29c. LICENSE NUMBER BE OCME 2 COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) . KONGK LWO 111 Penn Street, Baltimore, Maryland 21201

EARL

1 M 2 - F

6. AGE (In yrs. last birthday)

61

5. SEX

CERTIFICATE OF DEATH

RANDOLPH

DAYS

IF UNDER 1 YEAR IF UNDER 24 HRS.

HOURS

BARRA.

95 20559 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2. DATE OF DEATH 3. TIME OF DEATH YEAR JULY 01,1995 15:35 P 7. DATE OF BIRTH (Month, Day, Year)
JUNE 21, 1934 6. BIRTHPLACE (State or Foreign CAROLINA N. 9c. COUNTY OF DEATH n/a 10d. INSIDE CITY
VEMITS?

1 YES 2 NO

10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES 14. RACE — American Indian, Black, White, etc. Specify: BLACK 16b. KIND OF BUSINESS/INDUSTRY TRADES-MARYLAND **JOHNSON** 20c. LOCATION — City or Town, State GREENVILLE. N.C

> Approximate Interval Batween **Onset and Death**

AVENUE

24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO

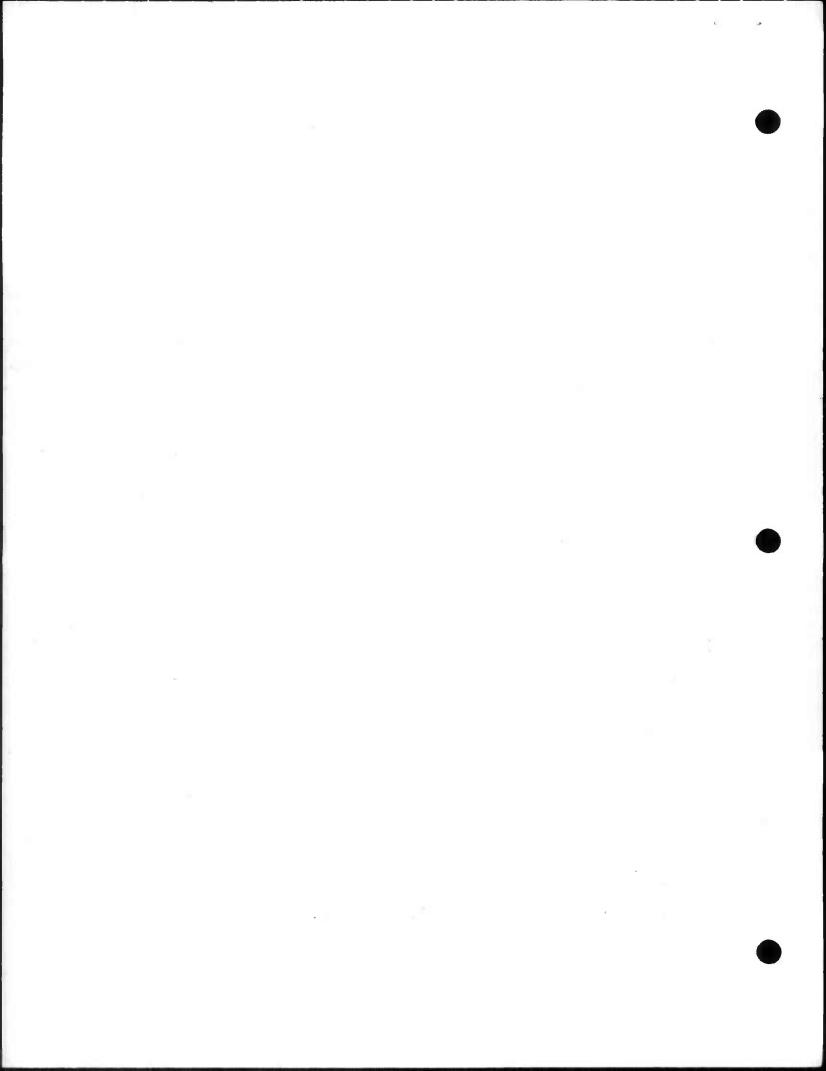
PARMON

28d. DESCRIBE HOW INJURY OCCURED

261. LOCATION (Street end Number or Rural Route Number, City or Town, State)

29d. DATE SIGNED (Month, Day, Year)

JULY 02,1995



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hyginer prior to buriat, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury or other traumatic event he marked examiner must be marked.	The state of the s
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	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTI	MENT OF H	EALTH AND I	MENTAL HYGIE		
	1. DECEDENT'S NAME (First, Middle, Last) MELVIN ROGE:	RS				2. DATE OF DEATH MONTH	2nd 1995	3. TIME OF DEATH 7:10 A
0.00		1XXM 2 □ F		F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) NOV. 9, 19	8.8	NRTHPLACE (State or Foreign Country) N. CAROLINA
OR		eet and number) HOPKINS HOSP:			R LOCATION OF DE	ATH	9c. COUNTY	of DEATH
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	,	10c. CITY, 1	TOWN OR LOCAT				10d. INSIDE CITY
	MARYLAND	n/a			LTIMORE ZIP CODE		T	1 YES 2 NO
FUNERAL		CLAY STREET			21202		UNITE	
ВУ	11. MARITAL STATUS 1 Never Married 2 Natural State Sta	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT	U.S. ARMED 2 WWO TES A	13. WAS DECI If yea, spe 1 YES	city Cuban, Mexical	IIC ORIGIN? (Specify Yon, Puerto Rican, etc.)		RACE — American Indian, Black, Whita, etc. Specify: BLACK
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5 +)	16e. DECEDENT'S US (Give kind of word life. Do NOT use n LABO	k done during mos etired.)	N t of working		RUCTION	
BE CON	17. FATHER'S NAME (First, Middle, Leist) HARVEY ROGER	RS	18. MOTHER'S NAI	AME (First, Middle, Melden Surname) SSIE ROGERS				
P HELEN ROGERS 1710 BARCLAY STREET, BALTIMORE, MD							21202	
	20a. METHOD OF DISPOSITION 1 XX Surial 2 Cremation 3 Figure 4 Donation 6 Other (Specify)	nel from State cemet	PLACE AND DATE OF I tery, cremetory or other [. ZION	DISPOSITION (Nar CEMETER	ne of		DCATION — CITY OF	
	21. SIGNATURE OF FUNERAL SERVICE LICE Bernary D	Johnson		WM.		FH1101		
	23. PART I. Enter the disease, or contained the second shock, or heart failure. If immediate CAUSE (Final disease or condition resulting in desth)		STATIC			CANC		Approximate interval Between Onset and Desth
CERTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that Initieted events resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF):					
AL	PART II. Other eignificant conditions	contributing to deeth but	t not reaulting in t	the underlying	causa given in i	Part I. 24a. WAS AF PERFO	RMED7	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YES		UNCERTAIN	1 100		1 TES 2 10 NO
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:		THER:	5 Residence	Other (Constan		
	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME O	F 28c. INJU WOR	RY AT	28d. OESCRIBE HOW	INJURY OCCURE	D
TED BY	2 Accident Investigation 3 Suicida 6 Could not be 4 Homicide detarmined	26s. PLACE OF INJURY — building, atc. (Specify	- At home, farm, street)	et, fectory, office	ES 2 NO	261. LOCATION (Street City or Town, State		iral Route Number,
COMPLETED		AN: To the beat of my knowled On the basis of examination a						
	29b. SIGNATURE AND TITLE OF CERTIFIER	90	The state of the s		29c. LICENSE NUM			NED (Month, Day, Year)
TO BE	Mark J. Bas	COMPLETED CAUSE OF DEAT	-	met.	N330	9	F0 4	02 95
	HARK J. BASKERN	ILE M.D.	STOWER.	BLOG.	JOHNS H	LEGKINS HOS	ATAL	BALT. MD
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT	URE CALL					

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after de-	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the furbe filled within 72 hours after death with the State Dept. Of Health and Mental Hygiene prior to burial, cremation, or removal.
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	3. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the hurial-transit narmit Panes 1.2 a.	1	
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	REGISTRAR		CERTI	FICATE C	F DEATH	REG. N	O.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
	Adele Maria S	moot					DAY TOOF	YEAR		
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. last birthda) IF UNDER 1 YEA	R IF UNDER 24 HRS.	July 3,	1995	9:35 A M		
	218-58-4322	1 M 2 F		MONTHS DAY	-	7. DATE OF BIRTH (Month, Day, Year) NOV. 21,		8. BIRTHPLACE (State or Foreign Country)		
			77 YRS.			Nov. 21,	1917	Italy		
1	9e. FACILITY NAME (If not institution, give a	street and number)		9b. CITY, TOV	N OR LOCATION OF D	EATH	9c. COUN	TY OF DEATH		
CTOR	Greater Baltin	more Medi	cal Center	7	owson		R= 7	timore		
15	RESIDENCE OF DECEDENT				OWBOIL		Dal	CIMOIE		
DIREC	10e. STATE 10b. COUNT		10c. C	ITY, TOWN OR LO	CATION			10d. INSIDE CITY LIMITS?		
5	Maryland Ba	ltimore		Ba1	timore			1 YES 2 X NO		
1	10s. STREET AND NUMBER			T	101. ZIP CODE		10g. CITIZ	EN OF WHAT COUNTRY?		
FUNERAL	8638 Saxon Circ	1e		- 1	21236		1 '			
Ž	11. MARITAL STATUS		EVER IN U.S. ARMED	40 11110				S.A.		
正	1 Never Married 2 Merried	FORCES? 1	YES 2 XNO	13. WAS	ECENDENT OF HISPA specify Cuben, Mexico	NIC ORIGIN? (Specify Y an, Puerto Ricen, etc.)	ee or No	14. RACE — American Indian, Black, White, etc.		
B	3 X Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES	1 🗆 '	ES 2 NO Specif	fy:		Specify:		
03	45 0500051170 0011	I						White		
ETE	15. DECEDENT'S EDU (Specify only highest grade		(Give kind o	S USUAL OCCUP	TION most of working	16b. KIND OF B	USINESS/INDU	ISTRY		
4	Elementary/Secondary (0-12)	College (1-4 or 5 +	IIII. DO NOI	use retired.)						
2 P			Home	emaker		Ow ₁	n Home			
once.	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maide	n Sumame)			
10 m	Eugenio Ossa	ni			Concet	tina Iz:	ZO			
E B	19e. INFORMANT'S NAME (Type/Print)		19b. MAJLIP	IG ADDRESS (Stra		Route Number, City or To	_	Code)		
TO BE COM	Eugenio W. Smoot	(son)				imore, MD				
8	20a. METHOD OF DISPOSITION	(5011)					2123			
5	1 Buriel 2 Cremation 3 Bem	oval from State	20b. PLACE AND DAT cemptery, grematory of	e of disposition other place)	(Name of			Ity or Town, State		
E	4 □ Donation 5 to Other (Specify) Entombment Parkwood Cem. Mausoleum 7/7 Baltimore, Maryland									
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc.									
E	9705 Relair Pd Relations ND 21226									
<u></u>	9705 Belair Rd., Baltimore, MD 21236									
8	23. PART I, that the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or reapiratory arrest, about, or heart failure. List only one cause on each line.									
E	IMMEDIATE CAUSE (Final									
Ē	disease or condition - Hepatic Tailure I week									
any injury, or other traumatic event, the medical examiner must be DICAL CERTIFICATION	QUE TO (OR AS A CONSEQUENCE OF):									
5 -		Hen	44-					18		
ry, or other traumatic CERTIFICATION	Sequentially list conditions,	DUE TO	OR AS A CONSEQUENCE	OE)·				Y PZ		
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를 입	PART II. Other significant condition	e contribution to	teath but not regulation	de the contests	lan acusa alius la	Book I I are supply				
EDICAL	11 = +/						N AUTOPSY PRMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
E 5	Hyper Iroph	· c Ca	irdiamyo	path		1 □ YES	2 NO	COMPLETION OF CAUSE OF DEATH?		
shows			,	,				1 TYES 2 NO		
5 5	DID TOBACCO USE CONT	RIBUTE TO CAI	JSE OF DEATH Y	ES I NO	UNCERTAIL	N 🗆				
SICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DE							
E E	EXAMINER?	HOSPITAL:	-v	OTHER:						
5 ≥		/	ER/Outpatient 3 DOA		ome 5 - Residence					
BY PHY	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF (Month, Da			NJURY AT WORK?	28d. DESCRIBE HOW	INJURY OCCU	IRED		
B M	1 Natural 5 Pending 2 Accident Investigation			M 1 [YES 2 NO					
ED E	3 Suicide 8 Could not be	28e. PLACE OF	INJURY — At home, ferm itc. (Specify)	atreet, factory, o	fice	281. LOCATION (Street	end Number o	v Rural Route Number,		
4 12	4 Homicide determined		itot (opoony)			City or Town, Stett	9)			
	290. CERTIFIER 1 CERTIFYING PHYSI	CIAN. To the best of								
MPL			ny knowledge, death occu							
8	2 MEDICAL EXAMINE	N. Off the basis of ex-	mination end/or investigat	ion, in my opinior	, death occured at the	time, date end place, e	nd due to the	ceuse(s) end manner es stated.		
	296. SIGNATURE AND TURNS OF CERTIFIES	1	1501		29c, LICENSE NUI	MBER	29d. DATE	SIGNED (Month, Day, Year)		
IMPORTANT: It item O BE COMPLE	(V~~/(-160	real	nell or	10	10309	48	1 7	13/9-		
≧ 2	TO MAME AND ADDRESS OF PERSON WH	O COMPLETED CALS	OF DEATH (ITEM DE) (THE	e. Print	101	70		13117		
	I ames K	· Lo-to		4D	CRM					
	II 31 DATE EII 80 MANNT Des West	do prouper	1 1 1 1 1		0011					
	31. DATE FILED (Month) Day 1995	A. HEGISTRAF	S SIGNATURE							
		June ar mine	workerell							

Pages 1, 2, 3 should

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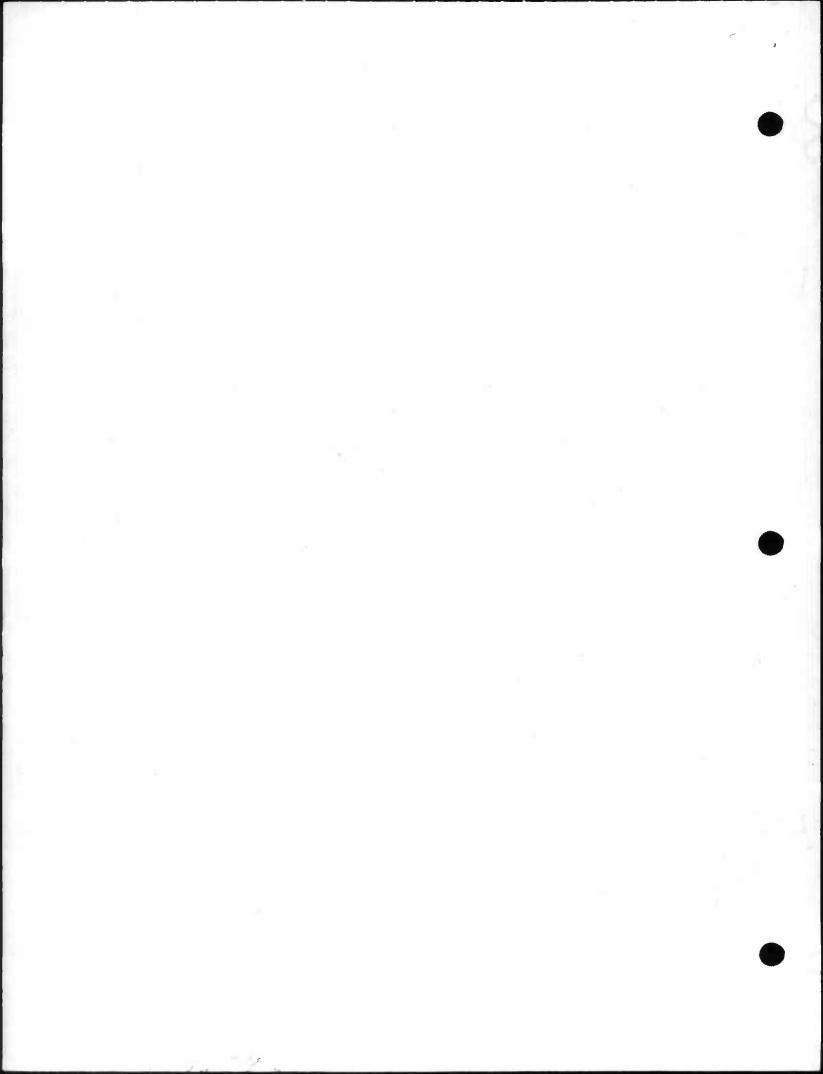
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95 20562 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATN Daniel July 05. 1995 Stewart 12:30 P A SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 6. BIRTNPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 7 DATE OF BIRTH MAY 31,1958 BALTIMORE, MD 214-64-8340 37 1 XNX 2 | 1 DAYS HOURS 9a. FACILITY NAME (If not institution, give str 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR MARYLAND **GENERAL** HOSPITAL BALTIMORE CITY n/a RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c CITY TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 YES 2 NO MARYLAND n/a BALTIMORE FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? ARGYLE 1103 **AVENUE** 21201 UNITED STATES 11. MARITAL STATUS
1 Never Married 2 Married 12. WAS DECEDENT EVER IN U.Q. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, etc. IF YES, GIVE WAR OR DATES 1 TES 2 XO BY Specify: Specify: BLACK 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Sec College (1-4 or 5+) COUNSELOR CHILDREN 17. FATNER'S NAME (First, Middle, Last) 18 MOTNER'S NAME IAME (First, Middle, Malden Surnan ELIZABETH ANN **HENRY** STEWART "LOWERY JOHN BE notified 19a. INFORMANT'S NAME (Type/Print) 19th. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6133 SAINT REGIS ROAD, BALTIMORE, MD 21206 2 TAMMIE HICKS pe 20a METNOD OF OISPOSITION
1 Devial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State must PARBUTUS other PIMEMORIAL ARBUTUS, MARYLAND 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH **AVENUE** ulas medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition AIDS event, resulting in death) unknown DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury other 1 DUE TO (OR AS A CONSEQUENCE OF)that initiated events reauiting in death) LAST 6 Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN ALTTOPSY Infective Endocolitis ашх 1 TYES 2 NO shows t ☐ YES 2 XXNO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO K UNCERTAIN 23 26. PLACE OF DEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL Tem I HOSPITAL: XXInpatient 2 ER/Outpatient 3 DOA 1 - YES 2 NO 4 Nursing Nome 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO BY E HOSPITAL OR ATTENDING F E FUNERAL DIRECTOR: After d within 72 hours after death HTANT: If Itom 28 is man 2 Accident 28e. PLACE OF INJURY — At home, farm, streat, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 1 X CERTIFYINO PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and menner as stated. TO THE HOSPITAL
TO THE FUNERAL I
BE filed within 72 h
IMPORTANT: If II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE Klico, M.D 89246 19

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATN (ITEM 27) (Type, Print)

Luis Mejico, M.D. c/o Maryland General Hospital

1. 37 REGISTRAR'S GNATURI

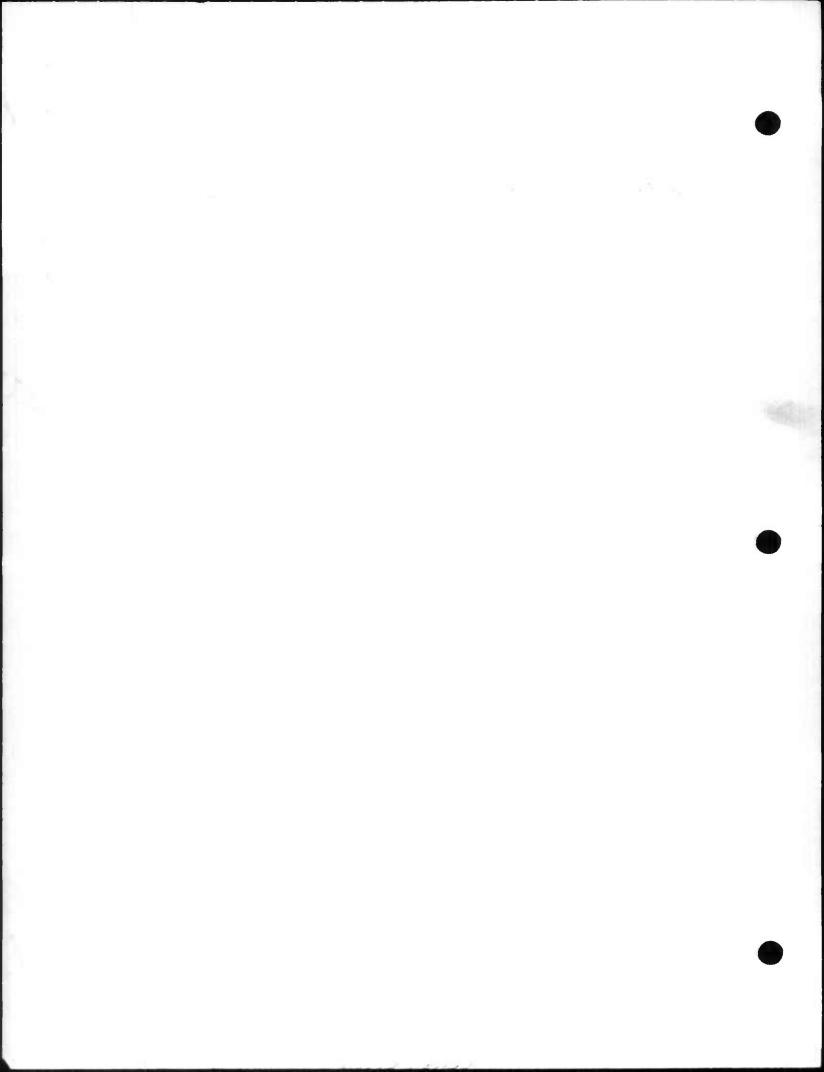


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

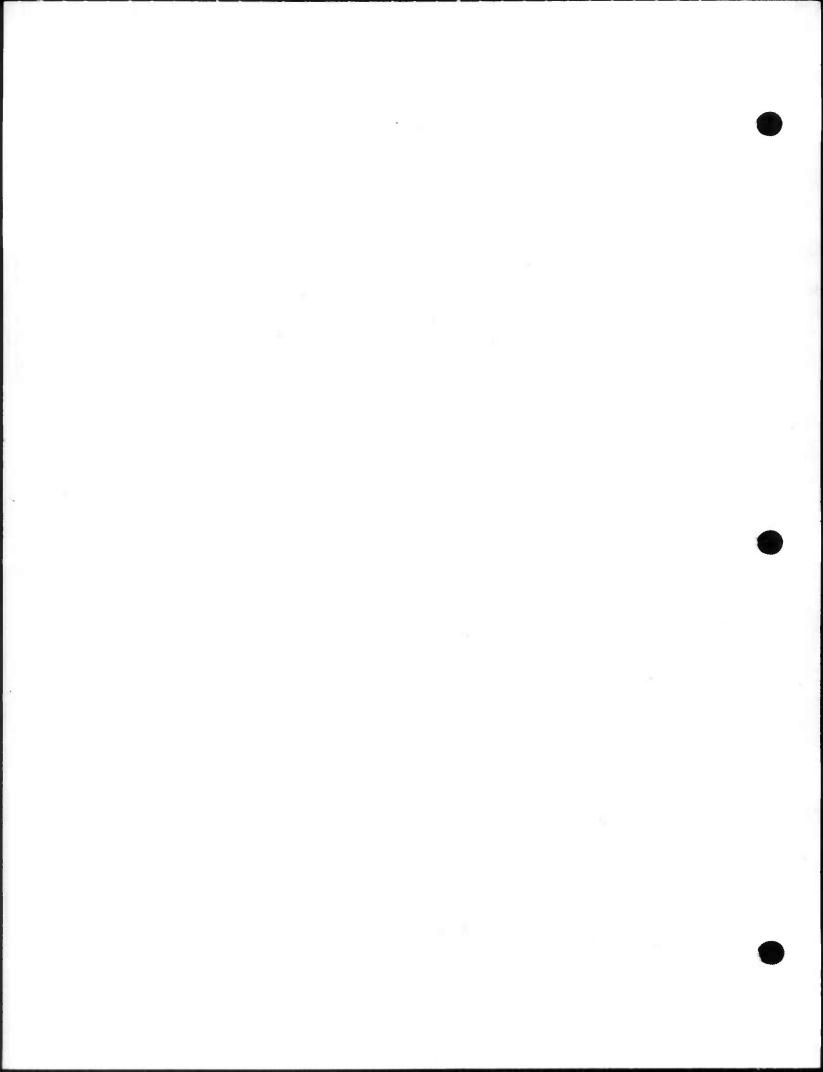
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			SIAIE UF I	MARTLAND	ERTIF	ICATE O	F DEAT	AND MEI H	REG. NO		
	1. DECEDENT'S NAME (First	+ .	Saleman	ES JOSE	PH SO	LOMON, S	R	_ i	DATE OF DEATH D	N, 19	YEAR 3. TIME OF DEATH
	217-22-3409		5.5EX 1 ∰. M 2 □ F	6. AGE (In yrs. Is	st birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS		MIN.	DATE OF BIRTH Month, Day, Year) 19-08-192		6. BIRTHPLACE (State or Foreign Country) MARYLAND
TOR 1	NORTH AR	UNDE	11	PITAL		96. CITY, TOWN	^		ARYLAND	1	IV OF DEATH
DIRECTOR	10a. STATE	10b. COUNTY	1		10c. CIT	r, TOWN OR LOC					10d. INSIDE CITY
	MARYLAND		NNE ARUN	IDEL		GLEN E	BURNIE				1 TYES 2 TO NO
FUNERAL	305 7TH AVE		J.E.				ior. ZIP COOE	1060			EN OF WHAT COUNTRY?
ΒY	11. MARITAL STATUS 1 Never Married 2 3 Wildowed 4 Divo	rced	KOREAN	IT EVER IN U.S. AI VI YES 2 VAR OR DATES CONFLIC	NO	If yes,	ECENDENT OF specify Cuban ES 2 NO	HISPANIC O , Mexican, Pu Specify:	RIGIN? (Specify Yes arto Rican, etc.)	or No-	I4. RACE — American Indian, Black, Whita, atc. Specify: WHITE
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	17. FATHER'S NAME (First, M		SOLOM	ION	LINEM	AN	16. MOTH		irst, Middle, Maiden	& E.	
BE	JOHN 19a. INFORMANT'S NAME (1)	ROBINS	OMON		b. MAILING	AODRESS (Stree	and Number of		Number, City or Tow	n Stata 7in (Conta)
임	JAMES JOSEP	H SOLO	MAN, JR.						EN BURN		
	20a. METHOD OF OISPOSITI 1 Burlel 2 Crematio 4 Donation 5 Other	n 3 🗆 Remo	oval from State	cemetery, cr	ematory or ot			7	OATE 20c. LO	CATION — C	ty or Town, State
	21. SIGNATURE OF FUNERA		ENSEE	GLEN	HAVE	N. MEMOR	AND ADDRESS	ARK 1	995 GLEN	BURN	IIE, MD.
	11/11	Da.	10	5	11/	/	OND A				NERAL HOME,
	23 PART I Enter the di					1 () 1	DITEMIT	C' MIXIC			
	shock, or he	seases, or c eart fellure. I	complications the	t coused the ti	eth. Do n	ot enter the m	BURNT	g, auch as	cardiec or respi	ratory arre	
	shock, or he IMMEDIATE CAUSE (Fin disease or condition resulting in death)	part reliure.	HEPA"	he Enc	e pha	ot enter the m	ode of dyln	E, MAR g, auch as	cardlec or respi	ratory arre	Interval Between Onset and Death Mmths
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CATION	IMMEDIATE CAUSE (Find disease or condition resulting in death) Sequentially list condition if any, leading to immediate. Enter UNDERLYI	dons, dilate	e. HEPAT	O- VENO	OUENCE OF	lupathy ndrum c	ode of dyln	g, auch as	cardlec or respi	LOGIL ratory arre	Interval Between Onset and Death Months Fuggal years Sevigal
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ပ္	IMMEDIATE CAUSE (Find disease or condition resulting in death) Sequentially list condition if any, leading to immediate. Enter UNDERLY CAUSE (Disease or Injustrat initiated events	ons, diate	e. HE par DUE TO DUE TO DUE TO OUTE	OR AS A CONSE ON AS	OUENCE OF OUENCE OF OUENCE OF OUENCE OF	lupathy ndrum c : (?na : (?na)	falu	g, auch as	cardlec or respl	AUTOPSY MEO?	Interval Between Onset and Death Months SEVERAL YEARS SEVERAL YEARS? Mail
MEDICAL C	Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition in the cause. Enter UNDERLY! CAUSE (Disease or Injuit that initiated events resulting in death) LAS	ons, diate NG ry	DUE TO DU	(OR AS A CONSE ON FMA (OR AS A CONSE AND CONSE (OR AS A CONSE (OR AS A CONSE (OR AS A CONSE (OR AS A CONSE	ED MA OURNCE OF MWW (OURNCE OF VE (lypathy ndrum (): Rna Chi SEas	falv	yen In Part	I. 24a, WAS AN PERFOR	AUTOPSY MEO?	Interval Between Onset and Death Months SEVERAL YEARS SEVERAL YEARS WAIT YEARS 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE
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ED BY PHYSICIAN: MEDICAL C	Sequentially list condition resulting in death) CAUSE (Disease or Injurt that initiated events resulting in death) LAS PART II. Other signification in death) DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 DIM 27. MANNER OF DEATH 1 Natural 5 1 2 Accident 1 3 Suicide 6	ons, diate NG ry T SE CONTR D MEDICAL	DUE TO DU	(OR AS A CONSE O-YEMA (OR AS A CONSE AND (OR	OUENCE OF OPENT INJUING	ot enter the manufacture of the	UNCE	ven in Part RTAIN RTAIN RTAIN 26d. NO 28f.	I. 24a. WAS AN PERFOR 1 YES 2	AUTOPSY MEO?	Interval Between Onset and Death Months SEVERAL YEARS EVENT YEARS 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
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ED BY PHYSICIAN: MEDICAL C	Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting to immercause. Enter UNDERLY! CAUSE (Disease or Injuthat initiated events resulting in death) LAS PART II. Other signification of the condition	ons, diate NG ry T Condition: SE CONTR D MEDICAL Pending neetigation Could not be determined IFYING PHYSIC CAL EXAMINER	EIST ONLY OFFI CAU DUE TO DUE TO DUE TO DUE TO DUE TO CLUTE PUE TO PUE TO CLUTE PUE TO PUE TO CLUTE PUE TO CLUTE PUE TO CLUTE PUE TO CLUTE PUE TO PUE TO CLUTE PUE TO PUE TO CLUTE PUE TO PUE TO	(OR AS A CONSE O— YENG (OR AS A CONSE ON (OR AS	OUENCE OF OUENCE OF OUENCE OF OUENCE OF OEAT OCCURRENCE OF OEAT OUENCE OF OEAT OUENCE OF OEAT OUENCE OF OEAT OUENCE OF OUENCE OF OEAT OUENCE OF OEAT OUENCE OUTPOST OUENCE OUTPOST OUENCE OUTPOST OUTP	ot enter the management of the	Talu Falu	ven In Part RTAIN RTAIN 28d. NO 28f.	I. 24a. WAS AN PERFOR 1 YES 2 Other (Specify) DESCRIBE HOW II LOCATION (Street a City or Town, State)	AUTOPSY MEO? NO	Interval Between Onset and Death Months EVERAL YEARS? WALLS EVERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO REO Rural Route Number, Cause(a) and manner as stated.
BE COMPLETED BY PHYSICIAN: MEDICAL C	Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting to immercause. Enter UNDERLY! CAUSE (Disease or Injuritial initiated events resulting in death) LAS PART II. Other signification in the s	ons, diate NG ny T Conditions SE CONTR D MEDICAL Pending neetigation Could not be determined IFYING PHYSIC CAL EXAMINER OF COSTUPER PERSON WHO	EIST ONLY OTTE CAU B. DUE TO DUE TO DUE TO DUE TO CLAN B. CONTRIBUTE TO CA HOSPITAL: 1 Offpatient 2 28a. DATE OF (Month, D. 28a. PLACE OF building. CIAN: To the besis of an	(OR AS A CONSE O— YENG (OR AS A CONSE ON (OR AS	OUENCE OF OUENCE OUTPORT OCCUPTORIST OCCUP	ot enter the management of the	Talu Falu	ven In Part RTAIN RTAIN 28d. NO 28f.	I. 24a. WAS AN PERFOR 1 YES 2 Other (Specify) DESCRIBE HOW II LOCATION (Street a City or Town, State)	AUTOPSY MEO? NO	Interval Between Onset and Death Months EVERAL YEARS? WALLS EVERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO REO Rural Route Number, Cause(a) and manner as stated.



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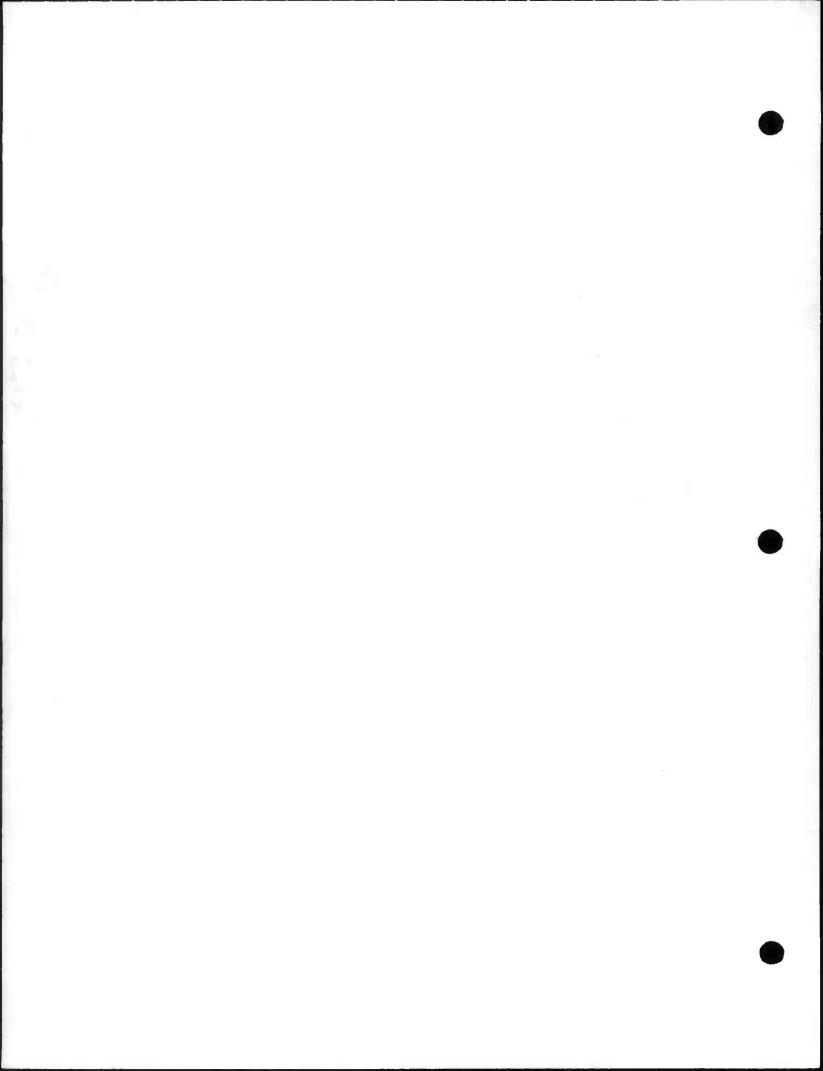
physician.	burial-transit permit. Pages 1, 2, 3 should	
INSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	must be notified at once.
xecuted within 24 hours after death. Pag	sician and completely filled in by the funeral di prior to burial, cremation, or removal.	d, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
w requires that the death certificate be	certificate has been signed by the attending physician and the State Dept. of Health and Mental Hygiene prior to	shows any injury, or other traus
OR ATTENDING PHYSICIAN: The law	DIRECTOR: After this certificate has nours after death with the State Dep	is marke
THE HOSPITAL	THE FUNERAL fled within 72	PORTANT: If Item 28

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND	/ DEPAR	TMENT OF	HEALTH AND	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	Gra	ce Evelyn Si	incla	ir		July 06	. 1995	5:45 A M
	4. SOCIAL SECURITY NUMBER 5	6. SEX 6. AGE (In yrs		F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Pay Year) MAR 13,19	6. BIRT	HPLACE (State or Foreign
	9e. FACILITY NAME (If not institution, give stree		THS.	9h CITY TOWN	OR LOCATION OF D		11 Mary	
O.B.	101 N. Beechwood Av			Catons		EATH	Baltimor	
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		40. 000	r, TOWN OR LOCA				
DIRECTOR	Maryland Baltimo	ore	10C. CIT	r, TOWN OR LOCA	Catonsv	ille		10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	101 N. Beechwood Av	7enue		10	1. ZIP CODE 21228	3	10g. CITIZEN OF USA	WHAT COUNTRY?
NO.		2. WAS DECEDENT EVER IN U.S.	ARMED	13. WAS DE	ENDENT OF HISPA	NIC ORIGIN? (Specify Yes	or No.— 14. RAC	E — American Indien,
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES 2X	Mo	If yes, s	ecify Cuben, Mexic 2 ANO Speci	en, Puerto Rican, atc.)	Blac	k, white, etc. white
	15. DECEDENT'S EDUCAT		DECEDENT'S	USUAL OCCUPATI	ON	185 KIND OF BUI		
COMPLETED	(Specify only highest grade cor	mpleted) College (1-4 or 5+)	(Give kind of wife, Do NOT us	vork done during m e retired.)	ost of working	Balt. Ci	ty Publi	С
MPL		Scl	noolte	acher		School S	ystem	
CO	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Middle, Malden	Surname)	
BE	Albert Gibsor			4000000		Mary Vogt		
2	Timothy A. Sinclair					Acute Number, City or Tow		, ,
	20a. METHOD OF DISPOSITION	20h BI AC	EANDDATED	E DISPOSITION /M	ama of	20-10	CATION ON T.	- AV.
	1 Donation 5 Other (Specify)	Metro	Crematory or ol	atory, I	nc. 07/0	07/95 Bal	timore. N	MD
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE Dawn F. McDo	nald	22. NAME A	ND ADDRESS OF FA	CILITY		
	Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228							
	23. PART i. Entar the diseases, or con shock, or heart failure. Lis	nplications that caused the o	daeth. Do n	ot anter the me	de of dying, suc	ch es cardiec or respi	ratory errest,	Approximate
	iMMEDIATE CAUSE (Final disease or condition				_			Interval Between Onset and Death
	resulting in death)	CERER			HRON	180111		
_		DUE TO (OR AS A CONS	EUUENCE OF):				
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONS	EOUENCE OF):				
CA	cause. Entar UNDERLYING CAUSE (Disease or injury							
E	thet initietad events resulting in death) LAST	DUE TO (OR AS A CONS	EOUENCE OF):				
	d							
MEDICAL	PART II. Other significant conditions of	ontributing to death but not	resulting i	tha undarlyin	g cause given in	Part i. 24a. WAS AN PERFOR		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ED	111100000000000000000000000000000000000	THE LICH		1938	IIG	1 YES 2	ENO.	OF DEATH?
Σ.	DID TOBACCO USE CONTRIB	SLITE TO CAUSE OF DE	ATH YE	S I NO F	UNCERTAI	N. O		1 TYES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			H (Check only one)	ONCERIAL	N LP		
SIC		OSPITAL: Inpatient 2 ER/Outpatient	3 DOA	OTHER: 4 Nursing Hon	e 5 🗆 Residence	6 Other (Specify)		
PH	27. MANNES OF DEATH Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME		URY AT	28d. OEŞCRIBE HOW II	NJURY OCCURED	
BY	2 Accident Investigation	20 50 00 00 00 00			rES 2 NO			
COMPLETED	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — AI I building, etc. (Specify)	nome, larm, si	treel, factory, offic	•	281. LOCATION (Street a City or Town, Stete)	ind Number or Rural F	Route Number,
PE	290. CERTIFIER CERTIFYING PHYSICIA	N: To the best of my knowledge, o	death occurre	d at the time, date	end place, and due	to the cause(a) end man	ner as stated.	
O.		On the beele of examination and/o						e) and menner es stated.
BE C	29b. STANATURE AND TITLE OF CERTIFIER	1	_		29c. LICENSE NUI	MBER	29d. DATE SIGNEO	(Month, Day, Year)
10	30. NAME AND ADDRESS OF PERSON WHO C	Xellena	u		D 285	95	►7/6/	25
	JASNEEM LAK	HANI, 722	EM 27) (Type,		EIGHTS (avE, B.	SUR LI	10 2/208
	31. DATE FILED (Month, Day, Year) JUL 07 1995	32 DEGISTRANS JONA UT			111-2			
	444	1						



DIVISION OF VITAL RECORDS, P.O. BOX 68760

		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMENT OF I	HEALTH AND	MENTAL HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	AY YEAF	3. TIME OF DEATH	
			recker				July 4, 190	_	11 43 PM	
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (I	n yrs. last birthday) 55 yas.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIF	THPLACE (State or Foreign untry)	
pino		218-36-9503 9a. FACILITY NAME (If not institution, give si		DD YRS.			Oct.1,19	39	Virginia	
. 2, 3 should	DIRECTOR	John Hopkins			96. CITY, TOWN	OR LOCATION OF DI		9c. COUNTY OF	FDEATH	
Sec 1	<u>ଲ</u>	10a. STATE 10b. COUNTY	,	10c. Cl	TY, TOWN OR LOCA	TION			10d. INSIDE CITY	
mit. Pa	1 1	Md. Ba	ltimore			ında1k			1 YES 2 X NO	
n. Insit per	FUNERAL	2007 Paulett	e Road		10	f. ZIP CODE	21222	10g. CITIZEN O	F WHAT COUNTRY?	
fing physician. the burial-transit permit. Pages 1, 2,	B	11, MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yas, sp	CENDENT OF HISPAI becify Cuban, Mexica 3 2 0 NO Specif	NIC ORIGIN? (Specify Yea in, Puarto Rican, atc.) y:	Bi	ACE — American Indian, ack, Whita, atc. ec/ly: White	
r attending use as the	ED	15. DECEDENT'S EDUC (Specify only highest grade	CATION	16a. DECEDENT'S	USUAL OCCUPATION Work done during me	ON	16b. KIND OF BUS	BINESS/INDUSTRY		
tal or for u	LET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	se retired.)	ost of working				
the hospital or detached for u	COMPL	8th		unem	ployed		n/			
by the		17. FATHER'S NAME (First, Middle, Last) Louis Swecke	r				ME (First, Middle, Maiden			
retained b 5 should 1 notified	BE	190. INFORMANT'S NAME (Type/Print)	T	19b. MAR INC	ADDRESS (Street		cty Flemi Route Number, City or Town			
5 5	욘	Patty Swecker					BAltimo			
may be		20a. METHOD OF DISPOSITION 130 Burlal 2 ☐ Cremation 3 ☐ Remo	20b.	PLACE AND DATE	OF DISPOSITION (N	ame of		CATION — City or		
Page 6 ma Il director, ner must		4 Donation 6 Other (Specify)	Ğ.	ardens	of Fait	h 7/7/	/95 Ro	ssvill	e Md.	
after death. Page 6 m by the funeral director, moval.		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	11		ND ADDRESS OF FA				
after death. y the funera noval.	_()	Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 23. PART I. Enter the diseases, or complications that caused the death Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate								
5 = 5		23. PART I. Enter the diseeses, or c shock, or heart feilure	omplications that caused list only one cause on as	the death bo	not enter the mo	ode of dying, auc	h ea cerdlec or respi	ratory arrest,	Approximata Interval Between	
Pe 9 1 24		IMMEDIATE CAUSE (Final		/					Onset and Death	
ted within 24 completely fills ial, cremation.		resulting in death)	DUE TO (OR AS A	CONSEQUENCE O	emorth	age			2 weeks	
D 2 - 2	7		00E 10 (011 A3 A	CONSCOUENCE	r):					
e be execut siclan and c nrior to buria traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE O	F):	• • • • • • • • • • • • • • • • • • • •				
tysiclar prior prior	2	CAUSE (Disease or injury	N							
n certificate nding physic Hygiene pri or other tr	E	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE O	F):					
£ 5 - 6	CE		l							
hat the deal by the ath and Menta y injury,	¥	PART II. Other significent conditions	contributing to death bu	it not resulting	in the underlyin	g cause given in	Part I. 24s. WAS AN PERFOR		4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
2 5 5 c	MEDIC						1 YES 2	2	COMPLETION OF CAUSE OF DEATH?	
requires been sign of Heaf	Σ	DID TORACCO LICE CONTR	NOUTE TO CAUCE OF	- DEATH W		7			1 TYES 2 NO	
- % B 0	PHYSICIAN:	DID TOBACCO USE CONTR			TH (Check only one)	UNCERTAIN	A IXI			
PHYSICIAN: The lanthis certificate has with the State Deprived, or Item 23	Sic	EXAMINER?	HOSPITAL:		OTHER:	ne 5 🗆 Rasidence	& Chhar (Specify)			
PHYSICIAL this certifi with the ted, or	并	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	28b. TIN	E OF 26c. INJ	JURY AT	28d. DESCRIBE HOW IN	NJURY OCCURED		
NG PHYS fter this eath with	ВУ	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆 1	YES 2 NO				
TTENDI TOR: A after d	COMPLETED	3 Suicide 6 Could not be 4 Homicide determined	26a. PLACE OF INJURY building, etc. (Special	— At home, term,	street, factory, offic	•	28f. LOCATION (Street a City or Town, State)	nd Number or Rura	Il Route Number,	
DIRECTOR A POURS	PLE	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my knowle	dge, death occurr	ed at the time, data	and place, and due	to the cause(a) and man	ner as stated.		
SPITA NERA hin 72	NO		a: On the basis of examination						e(a) and manner as stated.	
HE HO HE FU ed with	ш	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUN		29d. DATE SIGNI	ED (Month, Day, Year)	
TO THE HOSPITAL (TO THE FUNERAL D De filed within 72 h IMPORTANT: If II	TO B	1		ms		550	16	July S	, 1995	
		30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type	Johns	Hopkins	Bayvien Me	dical	Center	
		31. DATE FILED (Month, Day, Year)	32. REOISTRAR'S SIGNA	TUBE	4940	Eastern	Ave. Balt	, MD 2	1224	
	4	JUL 0 7 1995 Au	A A STATE OF THE S	44						
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2 7	PHYSICIAN:
DIVISION OF VITAL RECORDS	OSPITAL OR ATTENDING PHYSICIAN; TI
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DECEDENT SAME (FIR. MISSIS, Last) Second	A M Wign DLII								
4. SOCIAL SECURITY NUMBER 227-12-8988 1	DLII								
THE STATE THE STATE TO STATE T	NO								
RESIDENCE OF DECEDENT 100. STATE 100. STATE 100. STREET AND NUMBER 101. STATE AND RAYLAND 102. STREET AND NUMBER 103. STATE AND RAYLAND 104. STREET AND NUMBER 105. STREET AND NUMBER 106. STREET AND NUMBER 107. STATE AND RAYLAND 108. STREET AND NUMBER 109. STREET AND NUMBER 109. STREET AND NUMBER 110. MARITAL STATUS 111. MARITAL STATUS 112. WAS DECEDENT EVER IN U.S. ARMED 113. WAS DECEMBENT OF HISPANIC ONGIN? (Specify Viso or No— 114. RACE — American Indian, If yes, specify Cuben, Mastican, Purviso Rican, etc.) 115. DECEDENT'S EDUCATION 116. DECEDENT'S EDUCATION 117. YES 2 NO Specify: 118. DECEDENT'S EDUCATION 119. Specify Only highest grade completed; 119. WAS DECEDENT'S EDUCATION 119. Specify Only highest grade completed; 119. Specify Only highest grade completed; 119. NA 129. NATION NAME (First, Middle, Last) 130. WAS DECEDENT'S EDUCATION 141. RACE — American Indian, If yes, specify Cuben, Mastican, Purviso Rican, etc.) 151. Decedent's EDUCATION 152. Specify: 154. DECEDENT'S EDUCATION 155. DECEDENT'S EDUCATION 156. DECEDENT'S EDUCATION 157. FATHER'S NAME (First, Middle, Maiden Summarie) 159. INFORMANT'S NAME (First, Middle, Maiden Summarie) 159. INFORMANT'S NAME (First, Middle, Maiden Summarie) 1590. INFORMANT'S NAME (First, Middle, Maiden Summarie) 169. I	n,								
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15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY BAPTIST CHURCH N/A 2 YEARS 17. FATHER'S NAME (First, Middle, Last) JAMES A. STEWART 19e. INFORMANT'S NAME (Type/Print) JEROLYN STEWART 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEROLYN STEWART 20a. METHOD OF DISPOSITION 1 Business / Industry Runder of Particular Number, City or Town, State, Zip Code) 20a. METHOD OF DISPOSITION 1 Business / Content on State 1 Dogition S Other (Specify) 21. Signature of Funeral Service Licensee 12. Name and Daddress of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 2121									
Elementary/Secondary (0-12) College (1-4 or 5+) MINISTER									
JAMES A. STEWART 190. INFORMANT'S NAME (Type/Print) JEROLYN STEWART 190. PLACE AND DATE OF DISPOSITION 1 15/2 Burlai 2 Cremation 3 Ramoval from Stata 200. PLACE AND DATE OF DISPOSITION 1 15/2 Burlai 2 Cremation 3 Ramoval from Stata A Domation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO. MD. 2121									
JAMES A. STEWART 190. INFORMANT'S NAME (Type/Print) JEROLYN STEWART 190. PLACE AND DATE OF DISPOSITION 1 15/2 Burlai 2 Cremation 3 Ramoval from Stata 200. PLACE AND DATE OF DISPOSITION 1 15/2 Burlai 2 Cremation 3 Ramoval from Stata A Domation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO. MD. 2121									
190. INFORMANT'S NAME (TyperPrint) JEROLYN STEWART 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEROLYN STEWART 201. PLACE AND DATE OF DISPOSITION (Name of 7 - 10 - 9 5 DATE Cemetery, Cremetory, Cremetory or other place) MARYLAND NATIONAL MEM. PK. LAUREL, MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO. MD. 2121									
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	Calum (), Loung M. 1412 E. PRESTON ST. BALTO, MD. 21213								
ahock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition)	tween								
5 7 5 7 5 5 F	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions Lung Carcino ma								
DUE TO (OR AS A CONSEQUENCE OF):									
entry leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated any other initiated and i									
Cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in deeth) LAST Cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in deeth) LAST									
CAUSE (Disease or Injury that initiated events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF):									
Chronic Obstructive Pulmonery Disease 1 yes 2 No 1 yes 2 No 1 yes 2 No	USE								
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN MY	0								
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? 1 YES 2 NO THOSPITAL: 1 Inputient 2 ER/Outpatient 3 DOA 27. MANNER OF DEATH 28. INJURY 28. INJURY AT WORK? 10. OFFICE OF DEATH (Check only one) EXAMINER OF DEATH 28. INJURY AT WORK? 10. OFFICE OF DEATH (Check only one) EXAMINER OF DEATH 28. INJURY AT WORK?									
26. PLACE OF DEATH (Check only one) EXAMINER OF DEATH 26. PLACE OF DEATH (Check only one) 1									
27. MANNER OF DEATH 27. MANNER OF DEATH 1 Netural 5 Pending 28c. INJURY AT WORK? (Month, Dey, Yeer) 28c. INJURY AT WORK? 28c. INJURY AT WORK?									
1 Netural 5 Pending Investigation 2 Accident 5 Pending Investigation 2 Accident 2 A									
3 Suicide s Could not be datarmined 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify)									
29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.									
29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) 29a. MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.	fed.								
인 등 등 보 29b. SIGNATURE AND TITLE OF CERTIFICA 29d. DATE SIGNED (Month, Day, Year)									
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as state 29c. LICENSE NUMBER AS 240 232 Yec 30c. AS	5								
AS240232184C July 4 1993 MAS240232184C July 4 1993 MAS240252184C July 4 1993 MAS240252184C July 4 1993 MAS240252184C July 4 1993 MAS240252184C July 4 1									
31. DATE THE DON'T 1995 ALL 32 HOST DATE TO BE VELLET & HIVE BACTINGTE MD									

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the float hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE

	REGISTRAR		CERTIFIC	ATE OF DEATH	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) William Singleton			2. DATE OF OEATH MONTH DAY	YEAR 1998	3. TIME OF DEATH 5:35 A M		
DIRECTOR	214-14-7587	1 🖾 M 2 🗆 F	97 YRS. MO	UNDER 1 YEAR IF UNDER 24 HRS. NTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 09-14-9-7	8. BIRTH Count	HPLACE (State or Foreign ny)	
	98. FACILITY NAME (If not institution, give street Sinal Hospit		91	Baltimore	DEATH 9c. COUNTY OF DEATH N/A			
EC.	10a. STATE 10b. COUNTY		10c. CITY, T	OWN OR LOCATION			10d. INSIDE CITY	
	MD. BALTIN	MORE	CAT	ONSVILLE			1 YES 2 NO	
FUNERAL	315 INGLESIDE AVENUE			10f. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? USA		
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES U			13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No. If yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE	
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co	ompleted)	16a. DECEDENT'S USI (Give kind of work life. Do NOT use re	done during most of working	16b. KIND OF BUSIN	NESS/INDUSTRY	***************************************	
MPLE	UNK	College (1-4 or 5+)	UNK		UNK			
	17. FATHER'S NAME (First, Middle, Last)	037			AME (First, Middle, Maiden So	1		
BE	THOMAS SINGLET(JN			RY SINGLE			
2	BEVERLY CENTRON	አ ፐጥሟ		N. BELVEDERE			21215	
	20s. METHOD OF DISPOSITION	200	b.PLACEAND DATE OF C			ATION — City or To		
	1 X Burial 2 Cremation 3 Remove 4 Donation 8 Other (Specify)	al from State cer	metery, crematory or other ZION	CEMETERY 07		NSDOWN	E MD.	
	21. SIGNATURE OF FUNERAL SERVICE LICES		7	22. NAME AND ADDRESS OF FA	CILITY			
	· Mull	111111		ALBERT P.			015	
	23. PART i. Enter the diseeses, or co	mplications that ceuse	d the deeth. Do not	enter the mode of dying, suc	th as cerdiac or respira	tory arrest,	Approximete	
	shock, or heart fallura. Lis IMMEDIATE CAUSE (Final	•					Intarval Between Onset and Daath	
	disease or condition resulting in dasth)	DUE TO (OR AS	Bacte A CONSEQUENCE OF:	vial frem	onya		2 weeks	
NO	Sequentially list conditions, b.	DUE TO OR AC	A CONSEQUENCE OF):					
CATI	CAUSE (Disease or Injury							
CERTIFICATION	thet Initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):							
	PART II. Other significant conditions	contributing to death i	out not resulting in t	he underlying ceuse given in			. WERE AUTOPSY FINDINGS	
DICAL	Covancy outry disperse Performed? AMILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 25 NO COMPLETION OF CAUSE							
ME	Caranay arter dispose 1 yes 215 No 1 yes 215 No 1 yes 215 No							
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 18							
2		HOSPITAL:		28. PLACE OF DEATH (Ch				
HYS	27. MANNER OF DEATH	Izes Inpatient 2 ☐ ER/Out 28s. DATE OF INJURY	28b. TIME O	Nursing Home 5 Rasidence F 28c. INJURY AT		ILIBY OCCUPED		
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY		25d. DESCRIBE HOW INJURY OCCURED			
	3 Suicide 8 Could not be datarmined	28a. PLACE OF INJUR's building, atc. (Spe	Y — At home, farm, atrac city)	at, factory, offica	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
COMPLETED	29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.							
BE CC	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month).				(Month, Day, Year)			
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type, Pri	D 37	312	116	195	
	Jef Zibell MY	7720	Park Hei		Baltimo-e	MD	20515	
	31. DATE FILED (Month, Day, Year) JULEO 319957 9 444	32. REGISTRAR'S SIGN	LIL					

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PHYSICIAN: item 23

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2	Pag	5	9
BALIIN	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pag	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral dir be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner
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	SUDOL	d in b	med
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20	d within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi be filed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.	event,
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DIVISION OF VITAL RECORDS, P.O. BOX 68/60	the dea	the att	njury,
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95 20568 Iteml, 16a, Film725, 7/7/95, 1t FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH JUNE OSCA'R L 7:35 P UMIPSON SR 4. SOCIAL SECURITY NUMBER 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH nth, Day, Ye 48-18-8610 DAYS HOURS 9a. FACILITY NAME (If not institution, give str 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH SINAL HOSPI DIRECTOR HOSPITAL OF NA 10a. STATE 10h, COUNTY 10c. CITY, TOWN DR LOCATION 10d, INSIDE CITY LIMITS? NA Ma 1 YES 2 NO ore 10e, STREET AND NUMBER FUNERAL 10f, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3806 eisterstuwn SA Das 21215 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ASMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 FO Specify: 14. RACE — American Indian, Black, White, alc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced Specify Black ETED 15. DECEDENT'S EDUCATION ecity only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Sp (Give kind of work done life. Do NOT use retired. College (1-4 or 5 +) /PLUMBER COMPL 0 NA lumbing 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle hom oson 38 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (S Zip Code 2 ston HUND 21215 terstown METHOD OF POSITION 206. PLACE AND DATE OF DISPOSITI DATE etion 3 Other (Specify) **FUNERAL SERVICE LICE** NAME AND ADDRESS OF FACILITY H Was 0 Welbash md 21215 Errer the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each lim. 23. PART Approximate Interval Between IMMEDIATE CAUSE (Final disease or condition Onset and Death UREMIA resulting in death) DUE TO (DR AS A CONSEQUENCE OF): FAILLURE CHRONIC RENAL CERTIFICATION Sequentially list conditions, DUE TO (DR AS A CONSEQUENCE OF) If any, leading to immediate HYPERTENSION cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEDUENCE OF): that initieted events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 1 YES 2 NO

		,
DID TORACCO LISE CONTRIBUTE TO CALISE OF DEATH	VEG EL NIG EN LA CONTRACTOR DE LA CONTRA	

26. PLACE DF DEATH (Check only one) HOSPITAL: OTHER: 4 Nursing Home 5 Residence 8 Other (Specify)

Inpetient 2 - ER/Outpetient 3 - DOA 28a. DATE DF INJURY (Month, Day, Year) м

28c. INJURY AT 1 YES 2 ND

28e. PLACE OF INJURY — At home, farm, streel, factory, office building, atc. (Specify)

28d, DESCRIBE HOW INJURY OCCURED

281, LOCATION (Street and Number or Rural Route Number

BALTIMORE

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated.

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SIGNA	TORE AND TIT	ile of Certi	FIER	
	15hm	w		mD

29c. LICENSE NUMBER A52402321 JB 9912

29d. DATE SIGNED (Month, Day, Year) 1995

DF DEATH? 1 TES 2 NO

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

JOHN	w.		ATLEN	_
31. DATE FILED	(Month, O	ley, Ybar	1995	

25. WAS CASE REFERRED TO MEDICAL

NO

5 Pending

8 Could not be

determined

1 TES 2

27. MANNER OF DEATH

1 Natural 2 Accident

3 Suicide

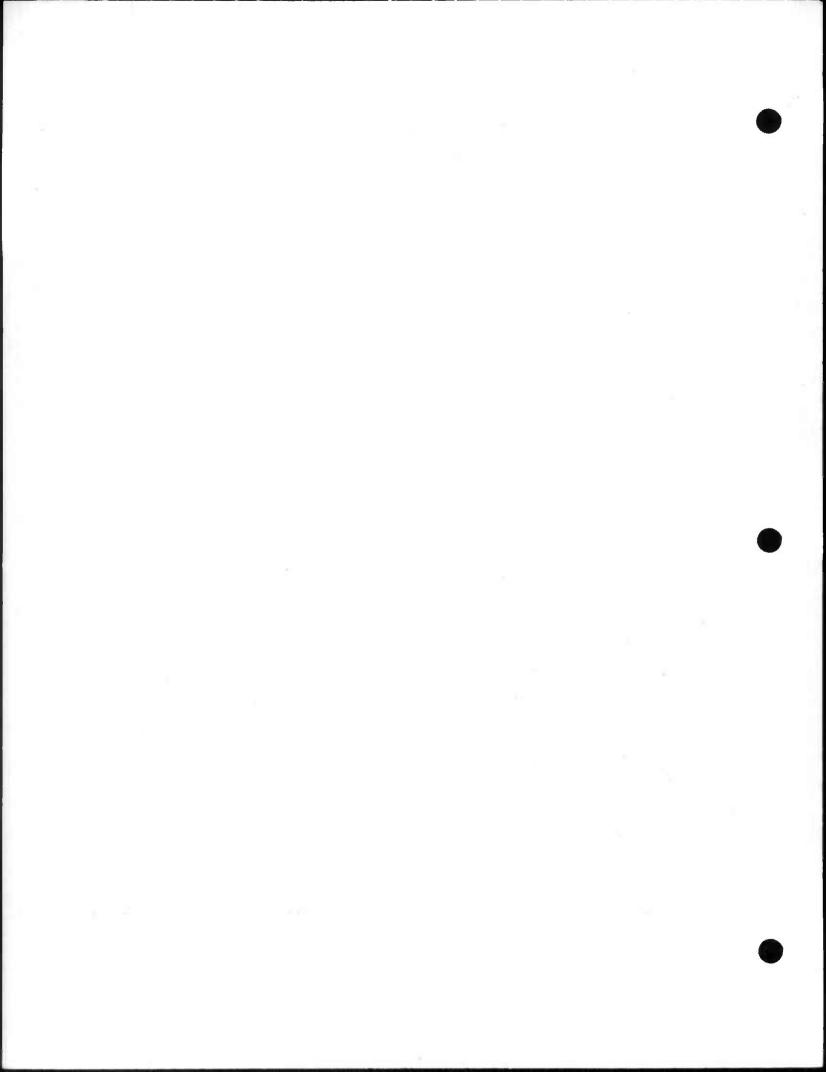
29a. CERTIFIER

4 Homicide

(Check only one)

2401 MD 32, REGISTRAR'S SIGNATURE Mander Redall

DHMH-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

PHYSICIAN: The law requires that the death certificate be executed within ZA hours after death. Page 6 may be retained by the hospital or artending physician.	is cert	the State Dept. of Health and Mental Hygiene prior	0
Sici	FUNERAL DIRECTOR; After this certificate has been signed	be filed within 72 hours after death with the State Dept. of Health	ITANT: if item 28 is marked, or item 23 shows a
TD TH	TH OL	be file	IMPO

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George Lowe.

31. DATE FILED (Month, Day, Year)

M.D

95 20569 Item9b 7-7-95 FilmG725 W.H.Per F/H STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ROBERT LOUIS TOLSON. JR. July 6, 1995 5:25 A 4. SOCIAL SECURITY NUMBER 5. SEX B. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country) 1th, Day, Year) DAYS HOURS 216-12-0879 1 X M 2 - F 72 Jan. Maryland 1923 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Meridian Nursing Home - Loch Raven Baltimore RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland N/A Baltimore City 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4602 Schley Avenue 21206 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 X NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried BY 3 Widowed 4 Divorced White WW II 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. OECEDENT'S EOUCATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 9 Security Officer Hospital 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Melden Surname) Robert L. Tolson Sr. Lillian Sanders BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mary L. Tolson 4602 Schley Ave. Baltimore, Maryland 20e. METHOD OF DISPOSITION

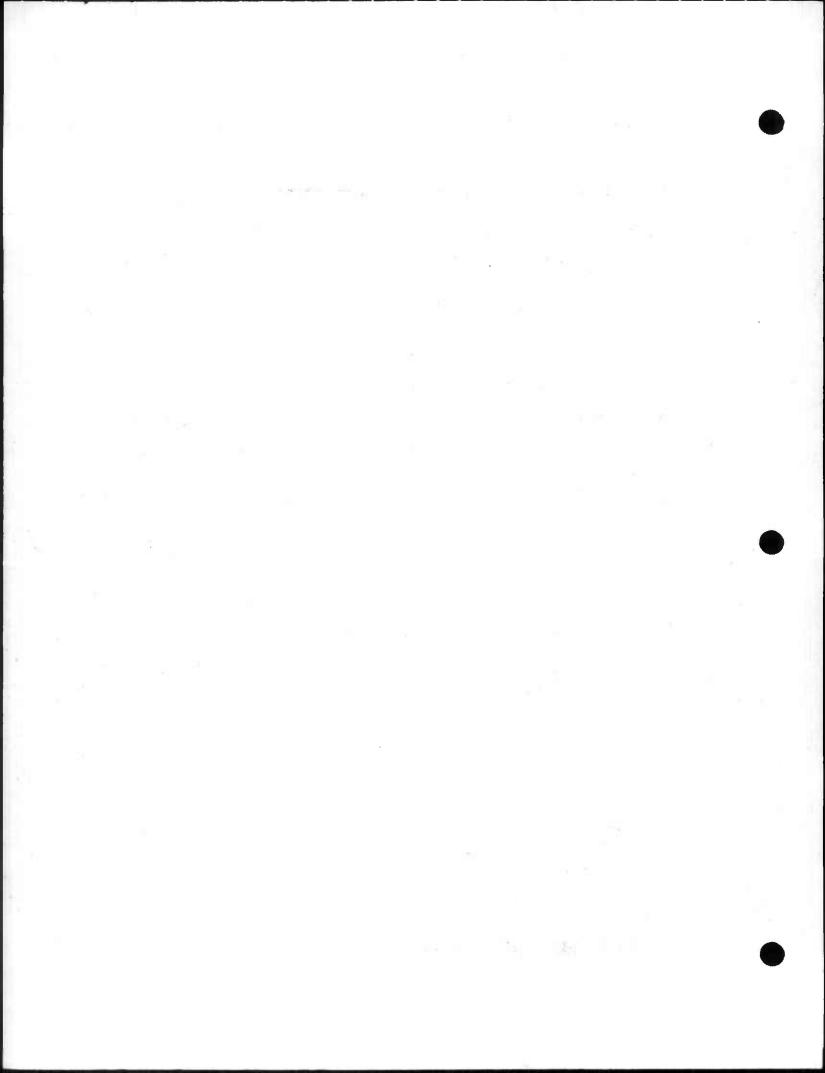
1 X Buriel 2 Cremetion 3 Rem

4 Donetion 6 A 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Cedar Hill Cemetery 7/8/95 Brooklyn 21. SIGNATURE OF FUNERAL SERVICE LICENSEI 22. NAME AND ADDRESS OF FACILITY Milton-J Knight Jr Baltimore, Md. 21214 Leonard J. Ruck, Inc. 5305 Harford Rd. 23. PART I. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cerdiec or respiratory street, shock, or heart fellure. List only one cause on each line. Approximate shock, or heart fellure. List only one of Interval Between IMMEDIATE CAUSE (Finel Onset and Death disesse or condition CVA resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate . Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMEO? 1 TES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DINCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 TES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ng Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, stc. (Specify) 3 Sulcide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER
(Check only one)

2 MEDICAL EVAMINED: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 296. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

2206 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5810 Belair Rd

Muchack



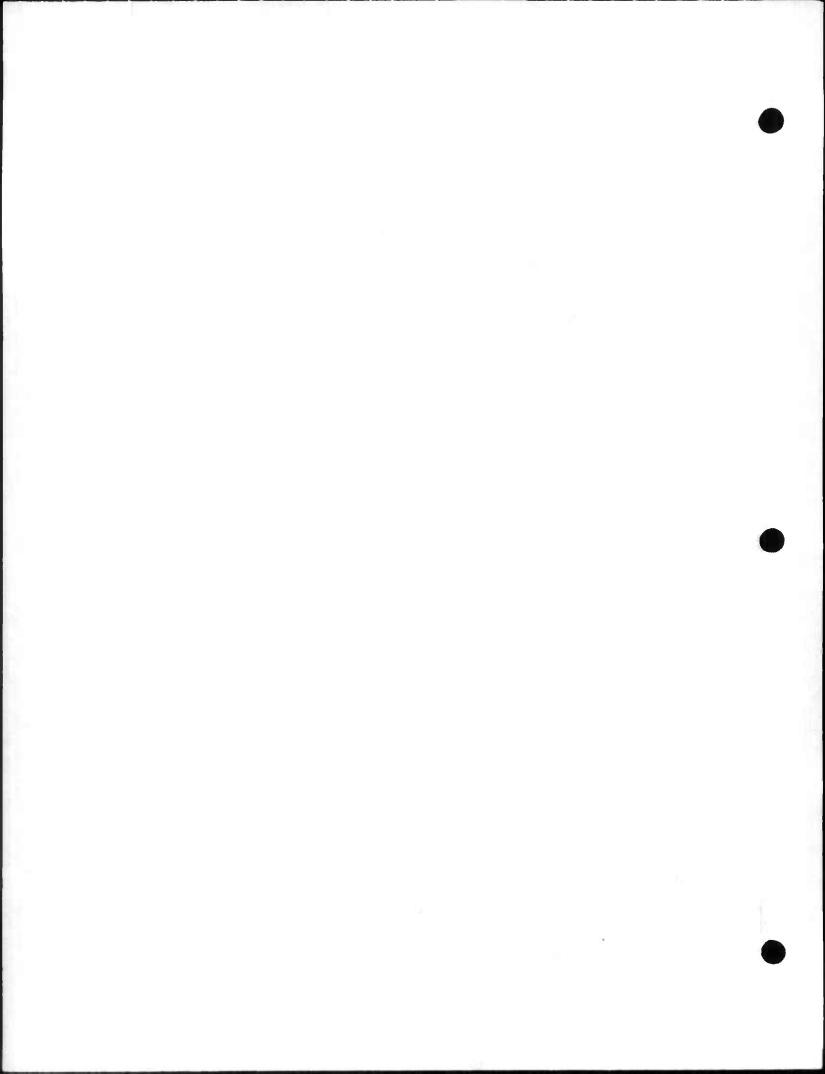
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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH John Green White 30 1995 5:12 June a. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) 8. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH (Morth, Day, Year) June 15 IF UNDER 1 YEAR IF UNDER 24 HRS. 1 😾 M 2 🔲 I 237-20-3368 7 4 YRS. 1921 South Carolina Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number, 9h. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR St. Agnes Hospital Baltimore n/a 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland 1 TY YES 2 NO Baltimore permit. 10e, STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? use as the burial-transit 202 West Culver Street 21229 USA hours after death. Page 6 may be retained by the hospital or attending physician, 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES NOV 42 - Oct 45 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 X Merried If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 X NO Specify: BY Specify: 3 Widowed 4 Divorced Nov Bl.ack ETED. 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for Health and Mental Hygiene prior to burial, cremation, or removal. Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12th Grade Pipe Mill Bethlehem Steel Corporation at once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surname) Elliott McMullen Della White notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Dorothy White 202 West Culver Street 21229 Baltimore, MD must be 20e. METHOD OF DISPOSITION

1 X Burlet 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Jů**ř**y 20c. LOCATION - City or Town, State cemetery, crematory or other place)
MD Veteran Cemetery/Garrison: Donation 5 - Other (Specify) Owings Mills, Maryland examiner 21. SIGNATURE QE FUNERAL SERVICE LICENSEE 22. NAME AND ADORESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216 the medical 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death within 24 disease or condition resulting in death) Errction B. O CUTCON AS A CONSTOUENCE OF): event. DUE TO (OR AS A CO traumatic ortes CERTIFICATION COS Sequentially list conditions, If any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events regulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? edema shows any non 1 TYES 2 NO 1 YES 2 NO t, of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 this certificate has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TES 2 NO OR ATTENDING PHYSICIAN: 1 | Inpatient 2 ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) the S 0 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) marked, 26b. TIME OF 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED with 1 Natural 5 Pending DIRECTOR: After the hours after death vitem 28 is mark 1 YES 2 NO BY 2 Accident Investigation 3 Sulcide 28e. PLACE OF INJURY -- Al home, farm, street, factory, office building, etc. (Specify) 26f. LOCATION (Street end Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide determined) THE FUNERAL DIRECT I filed within 72 hours at MPORTANT: If Item 2 29e. CERTIFIER
(Check only one)

2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner as stated. HDSPITAL TO THE FUNERA
be filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. SIGNATURE AND TITLE OF CERTIFIEF BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 3306 June 30, 1995 0 NAME AND ADDRESS OF PERSON OEATH (ITEM 27) (Type, Print) Scannine 31. DATE FILED (Month, Day, Year) 32 REGISTRAR'S SIGNATURE 07 1995



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DIVISION OF VITAL RECORDS,	
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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 0336 4. SOCIAL SECURITY 7. DATE OF B (Month, Da) 5. SEX IF UNDER 1 YEAR RTH DAYS HOURS 1 M 2 F YRS 0 use as the burial-transit permit. Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH FUNERAL DIRECTOR mor STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY ore YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE 2 executed within - Knours after death. Page 6 may be retained by the hospital or attending physician. I and completely filled in by the funeral director, page 5 should be detached for use as the burial-tran 12. WAS DECEDENT EVER IN U.S. ARME FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify 14. RACE — American Indian, Black, White, etc. If yes, specify Cubs 1 ☐ YES 2 Y NO iban, Maxican, Puerto Rican, atc.) 1 Never Married 20 ΒY Specify: 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTR (Specify only high (0-12)College (1-4 or 5+) ary land notified at once. 17. FATHER'S NAME (First, Middle, Last) enton BE 19h. MAILING ADORESS (SI 21218 2 20a METHOD OF DISPOSITION pe 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION must 2 Cremation 3 on 6 Other (Specify) 4 Donation FUNERAL SERVICE LICENSES other traumatic event, the medical examiner ans filled in by the filon, or removal. 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate interval Between shock, or heart feilure. List only one ceuse on each line. **IMMEDIATE CAUSE (Fine)** Onset and Death cremation, disesse or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): burial, CERTIFICATION attending physician and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Mental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING 8 requires that the death certificate CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 item 23 shows any injury, signed by the a Health and Men PART II. Other aignificant conditions contributing to deeth but not reculting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 NO this certificate has been DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) State EXAMINER? 1 TES 2 NO OTHER Inpatient 2 - ER/Outpatient 3 - DOA Nome 5 Residence 8 Other (Specify) the ŏ 27. MANNER OF DEATN 28a. OATE OF INJURY 26c. INJURY AT WORK? 26b. TIME OF INJURY 26d. OEŞCRIBE NOW INJURY OCCURED is marked, with Netural 1 YES 2 NO death v BY Investigation DIRECTOR: After Accident ATTENDING 26a. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 3 Suicida 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be hours after 28 4 Homicide Hem 8 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dash occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL (
TO THE FUNERAL D
DE filed within 72 h
IMPORTANT: If it HOSPITAL 2 MEDICAL EXAMINER: On mination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIEF 29c. LICENSE NUMBER 29d. DATE SIG NED (Month, Day, Year) BE 9 WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ILhiv. of 20 31. DATE FILED (Month, Day, Year)

JUL 60/9/1995

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 687604

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within chours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

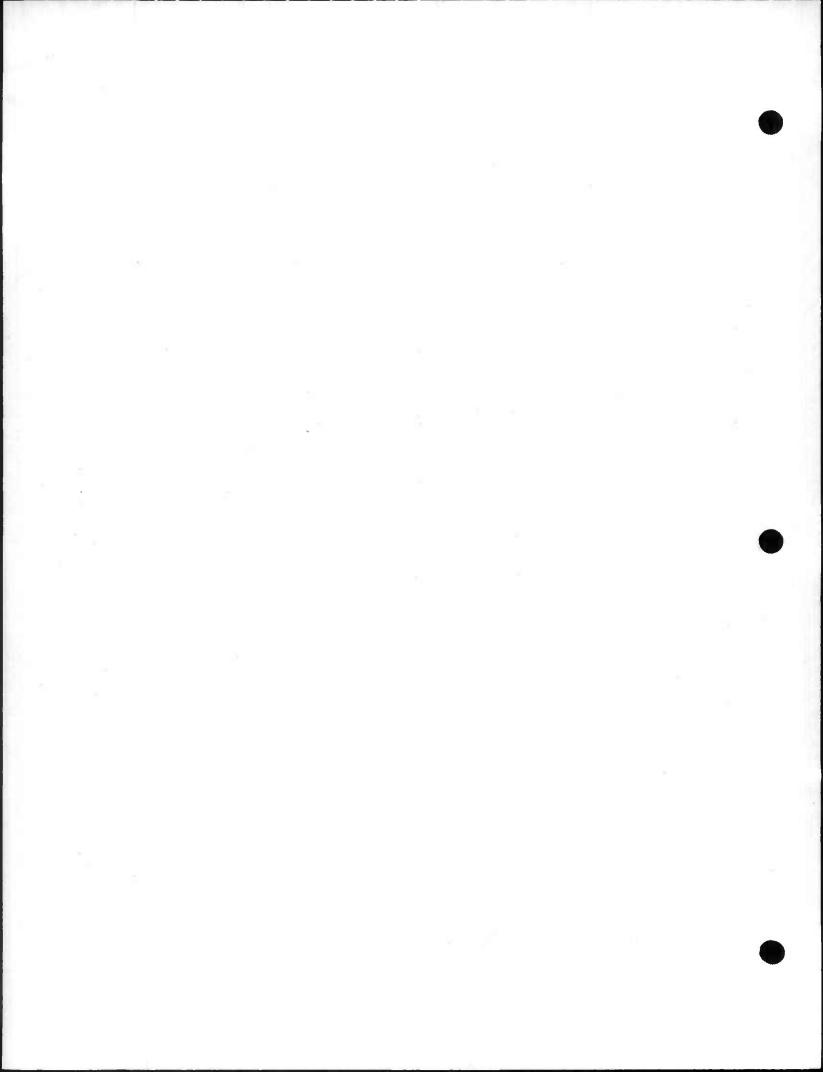
	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last)	MONTH DAY				[*] 005	YEAR	3. TIME OF DEATH 1:50pm m		
	Elsie Ann				-	E OF BIRTH		DIPTH	PLACE (State or Foreign	
	218-42-5279			ONTHS DAYS	HOURS MIN.	Fe	b. 11, 1	919	Mai	yland
_	9s. FACILITY NAME (If not institution, give st	reet and number)	9	b. CITY, TOWN C	R LOCATION OF D	EATH		9c. COUNT	Y OF D	EATH
DIRECTOR	351 Savannah Road				Essex				Bal	timore
JEC	10e. STATE 10b. COUNTY		10c. CITY, 1	TOWN OR LOCAT	ION			10d. INSIDE		10d. INSIDE CITY LIMITS?
	Md. Ba	ltimore			Essex					1 YES ZZ NO
FUNERAL	351 Savannah Road			101. ZIP CODE 21221			1	10g. CITIZEN OF WHAT COUNTRY? USA		
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES		13. WAS DEC	ENDENT OF HISPA	NIC ORIG	GIN? (Specify Yea	or No- 1	4. RACE	American Indian,
ВУБ	1 ☐ Never Married ② ☐ Married 3 ☐ Widowed 4 ☐ Divorced	2.AL NO ATES		Cify Cuban, Maxica Dig NO Specific				Specif	, White, atc. by:	
	15. DECEDENT'S EDUC	CATION	18e. DECEDENT'S US			Ι.				White
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5 +)	(Give kind of work life. Do NOT use n	k done during mo	st of working	- '	66. KIND OF BUS	INESS/INDU	STRY	
7	6th	College (1-4 or 5+)					own h	ome	9	
Š	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First	t, Middle, Maiden	Surname)		
BE	Henry Baumo	gartner			Ame	lia	Mil1	ler		
TO B	19a. INFORMANT'S NAME (Type/Print)				nd Number or Rural				,	
-	Mary Elizabet				h Road	Ba	1timon	ce Md	1 - 2	21221
	20s. METHOD OF DISPOSITION 1 XBurlel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other piece) Gardens of Faith 7/8/95 Rossville Md.									
- 1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AGORESS OF FACILITY									
	Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221									
	23. PART I. Enter the diseases, or o	complications that caused	the death. Do not.	enter the mo	Mace A	ve.	Balti	more	<u> </u>	Approximata
	23. PART I. Entar tha diseasea, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure—sist only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Metar Attack Carrier & Between Onset and Death OUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST	OUE TO (OR AS A	CONSEQUENCE OF):							
PHYSICIAN: MEDICAL C	PART ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO						WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
2	DID TOBACCO USE CONTR	RIBUTE TO CAUSE O	F DEATH YES	□ NO □	UNCERTAI	ΝП				1 YES 2 NO
X	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH		OTTOLICIAN	· •			1	
Sign	EXAMINER?	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outp		THER:	5 Residence	6 🗆 Oti	har (Specify)			
£	27. MANNER OF OEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O		JRY AT	28d. O	ESCRIBE HOW IN	JURY OCCU	RED	
BY	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆 Y						
	3 Suicide 8 Could not be 28s. PLACE OF INJURY — At home, farm, street, factory, office 28f. Li				281. LC	Bf. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
COMPLETED		CIAN: To the best of my knowl								and menner as stated.
	296. SIGNATURE AND TITLE OF CERTIFIER							(Month, Day, Year)		
TO BE	O He O To	Cler mos			0062	7	2	> Te	17/	95
F	30, NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Pri	MILL	mo 1	_12	37	- 1	1	
	31. DATE FILLU PRI DO 7 1905	31. REGISTRATE SIGN.	PRE		/					

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

		HEGISTRAH	CENTI	TOATE	PUEAIR	REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last) Tyla C	Wilkins			2. DATE OF DEATH MONTH	3,1995	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER 5. S	SEX 6. AGE (In yrs. last birthday	IF UNDER 1 YEA	IF UNDER 24 HRS.	7. DATE OF BIRTH		1:38 P M
ğ			XM 2 □ F	MONTHS DAY	7	(Month, Day, Year)	916	W.C.
3 should	œ	9a. FACILITY NAME (If not institution, give street a	and number)	(,)	N OR LOCATION OF DE		9c. COUNTY OF	DEATH
1, 2,	DIRECTOR	MOLGENERAL PRESIDENCE OF DECEDENT	MOSPITAL	1,2,	ALTO.		NIA	+
Pages	IRE	10a, STATE 10b, COUNTY		TY, TOWN OR LO				10d. INSIDE CITY
permit. Pages		10e. STREET AND NUMBER	LA E	ALT	101, ZIP CODE		100 CITIZEN OF	1 X YES 2 NO
ist	FUNERAL	5619 WayNE	tue.		2120	7	US.	
physician. burial-transit	N.	11. MARITAL STATUS 12. 1 Never Married 2 Married	WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO	13. WAS I	DECENDENT OF HISPAN specify Cuban, Maxican	IC ORIGIN? (Specify Yes		CE — American Indian, ck, White, etc.
	BY	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DATES		YES 2 NO Specify		Spe	My: Alack
r attending use as the	日日	15. DECEDENT'S EDUCATIO (Specify only highest grade comp	(Give kind or	S USUAL OCCUP	ATION most of working	16b. KIND OF BUS	INESS/INDUSTRY	DITTO
के के	PLET	Elementary/Secondary (0-12) Co	Hege (1-4 or 5+)		MAN	STEAM	T 4,42	=149
the hospit detached once.	COMPL	17. FATHER'S NAME (First, Middle, Last)		2 COLC		ME (First, Middle, Malden		KINDO
# 6 £	BE		LKINS		Lucy	Adam:		
retained to 5 should notified	2	19a. INFORMANT'S NAME (Type/Print)	LKINS SEL	- 8 8 7		Noute Number, City or Town	, State, Zip Code)	21200
ay be		200 METHOD OF DISPOSITION	20b. PLACE AND DATE	OF DISPOSITION	Member	DATE POOLOG	CATION - City or T	21207 Town, State
Page 6 mar il director, p ner must		1 Burial 2 Cremetion 3 Removal f	cemetery, crespatory or	other place)	Yark 7-	195 D	alto.	10
ter death. Page 6 m the funeral director, oval.		31. SIGNATURE OF FUNERAL SERVICE LICENSE	2		AND ADDRESS OF FAC		-West	51515
ins after des in by the fur removal.		Jums	12-12000	43	00 Wat	ash Are	Balt	s. Hd
		23. PART I Enter the diseases, or comp ahock, or hear failure. List	only one cause on asch line.	not entar the	moda of dying, such	aa cardiac or respi	ratory erreat,	Approximate Interval Between
10 mg 24		IMMEDIATE CAUSE (Final disease or condition resulting in death)	Sepsis					Onset and Death UNKNOWN
completely rial, cremati		s	DUE TO (OR AS A CONSEQUENCE					
e be executed sician and con nior to burial, traumatic en	NO	Sequentially list conditions, b.	Ischemia Bowel		se			
ysician prior to	CAT	If sny, leading to immediate cause. Enter UNDERLYING	TOTAL CONTROL OF THE	., j.				
leath certificate be attending physician mal Hygiene prior traur y, or other traur	CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE O	OF):				
ne death of the attend Mental Hy	CER	d						
nt the by the Ind M	EDICAL	PART II. Other significant conditions con	ntributing to death but not resulting	In the underly	ring ceuse given in	Part I. 24a. WAS AN PERFOR		b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
signed realth ws an						1 [] YES 2	X) NO	OF DEATH?
w request to the pt. of the 3 short	Σ.	DID TOBACCO USE CONTRIBU	ITE TO CAUSE OF DEATH Y	ES NO	UNCERTAIN			1 TES 2 NO
ATTENDING PHYSICIAN: The law requeCODR: After this certificate has been s after death with the State Dept. of I a ster death with the State Dept. of I a ster State Dept. of I a ster State Stat	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEA					
certific the Si	IYSI		Inpetient 2 ER/Outpetient 3 DOA 26a, DATE OF INJURY 26b, Til	4 - Nursing H	ome 5 Residence			
NG PHYS fler this c sath with marked,	ву Рі	1 Natural 5 Pending 2 Accident Investigation		JURY	WORK?	28d. DEŞCRIBE HOW IN	JUNY OCCUMED	
ENDING R: Afte er deal		3 Suicida 6 Could not be	28e. PLACE OF INJURY — At home, farm, building, atc. (Specify)	street, factory, o	ffice	28f. LOCATION (Street a: City or Town, State)	nd Number or Rural	Route Number,
R ATTI	E.	4 Homicide determined						
TO THE HOSPITAL DR ATTENDING PH TO THE FUNERAL DIRECTOR: After the be filed within 72 hours after death w IMPORTANT; If Item 28 is mark	COMPLETED		To the best of my knowledge, death occur the beale of exemination end/or investigation.					
FUNE within	- 11	29b. SIGNATURE AND TITLE OF CENTURIER	The owner of exemination end/or investigati	on, in my opinior	29c. LICENSE NUM			
THE OF THE SE FIELD) BE	Henri /lan	nom 12.D.		D3589			y 3,1995
_	2	30. NAME AND ADDRESS OF PERSON WHO COM	upleted cause of death (ITEM 27) (Typer, M.D. c/o Mai	e, Print)	Conoral	Hoomit-1		
				y Land	General	nospital	-	
		JULO 71995	2. REGISTRAR'S SIGNATURE]
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	ECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit Panes 1	B	
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PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 6 may be retained by the hospital or attending physicia	pletely f	rematio	s marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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THE HOSPITAL OR ATTEND	RAL DI	within 72 hours after	T. If ite
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TH CL	TO TH	be file	MPC

95 20574 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF CEATH 1995 June 30 Elizabeth Rice Warren 4:20 P.M. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. a, BIRTHPLACE (State or Foreign Nov. 12, 1912 HOURS Maryland 219-54-7803 1 M 2 X F 82 YRS. 9e. FACILITY NAME (If not institution, give atreet end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 308 Montgomery Street Prince George Laurel 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Prince George Maryland Laurel 1 X YES 2 NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP COOE 10g, CITIZEN OF WHAT COUNTRY? 308 Montgomery Street 20707 USA 11. MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY Specify: White 3 🕅 Widowed 4 🗌 Divorced COMPLETED 18e. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. OECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only his Elementery/Secondary (0-12) College (1-4 or 5+) 12 2 Homemaker Own Home 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Edward Crum Rice BE Eliza May Fox 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 John M. Warren, Jr. 137 Boone Trail, Severna Park, Maryland 21146 20a. METHOD OF OISPOSITION
1 ☐ Burlel 2 ☒ Cremetton 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State cemetery, crematory or other place)
Baltimore-Washington Crematory 4 Donation 8 Other (Specify) 7/1/95 Laurel, Maryland 21. SKWATUME OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate Interval Batween shock, or haart fallure. Llat only one cause on each line. d Death PHYSICIAN: MEDICAL CERTIFICATION

IMMEDIATE CAUSE (Final disease or condition resulting in death)	. VENTUCULAR APRHYTHMIA		Onset and Deat
Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): C. OUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF): d.	DUENSE	
PART II. Other algnificant condi	tione contributing to death but not resulting in the underlying cause given in Part I. FINANTA HISTORY OF AND MEDIUMSM	24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE

1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28e. OATE OF INJURY (Month, Dey, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO Accident 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number City or Town, State)

29e. CERTIFIER MYSICIAN: To the beat of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. (Check only one)

The state of the s	ny opinion, death occured at the time, date end p	lace, end due to the ceuse(e) end menner se atat
29b. SIGNATURE AND TITLE OF CENTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Dey, Year)

PRESS OF PERSON, WHO COMPLETED CAUSE OF ORACH (ITEM 27) (Type, Print)

1 A CHAID SZ (MUNUE GEORGE ST LAUREZ 30. NAME AND

32 REGISTRAR'S SIGNATURE

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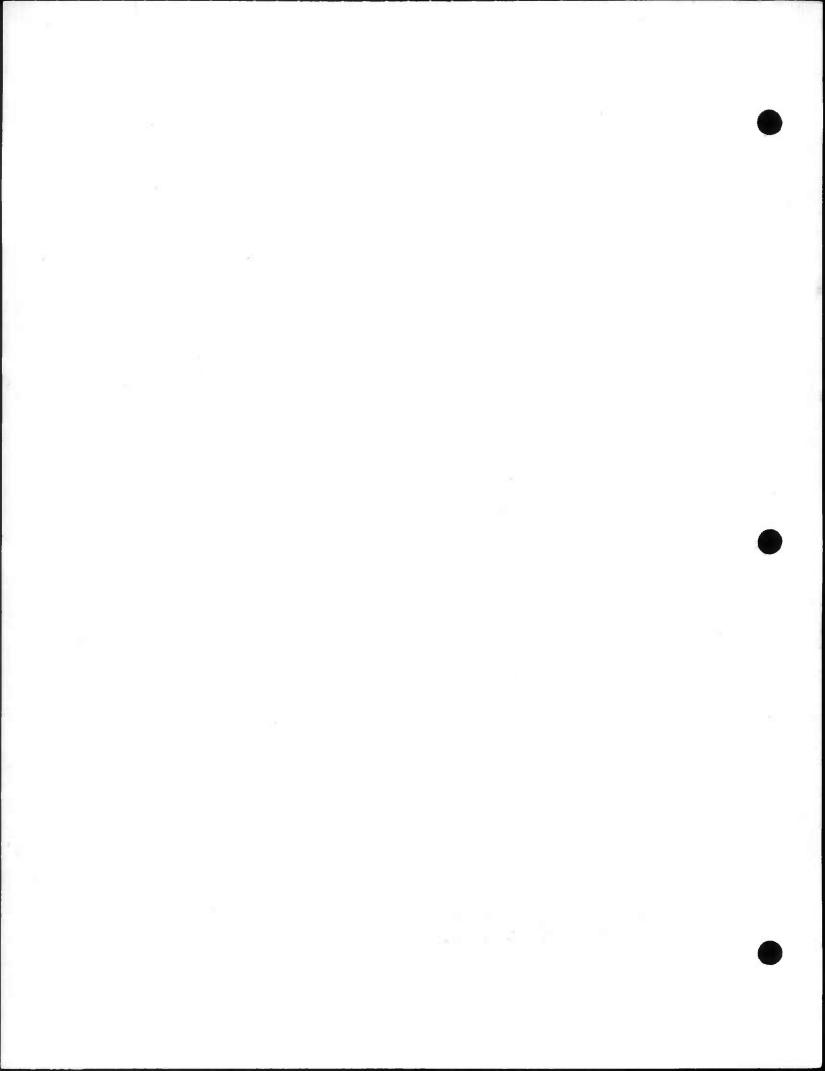
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IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

_	HEGISTRAN			Enile	CALE	Ur	DEAL		ě	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Lest) FELIX W. WATSO	N							2. DATE OF MONTH JUNE	DA	1995	YEAR	3. TIME OF DEATH 20:54 P M
	4. SOCIAL SECURITY NUMBER 244-36-7785	5. SEX 1 1 M 2 F	6. AGE (In yrs. let 70	st birthday)	7	IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTNPLACE (State					PLACE (State or Foreign		
NO.	9a. FACILITY NAME (If not institution, give a ST. AGNES HOSPITA				96. CITY, 1 BAL		ORE	ON OF DE				INTY OF D	
5 1	RESIDENCE OF DECEDENT												
DIRECTOR	MD BALT	•			r, town or BUTUS		TION						10d. INSIDE CITY LIMITS? 1 YES XX NO
FUNERAL	1241 FRANCIS AVE	NUE				10	r. ZIP CODE	212	227			SA	HAT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 X Married 3 Wildowed 4 Divorced	12. WAS DECEDENT FORCES? 12 IF YES, GIVE WI 1943-11	YES 2 1	RMED NO	If yes, specify Cuban, Maxican, Puerto Rican, atc.) Black, Whita, atc.) Types 244 NO Specify: Specify:								
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5 +) (G	live kind of w Do NOT us	rork done du e retired.)	USUAL OCCUPATION Ork done during most of working a retired.)							
OMPI	12 17. FATHER'S NAME (First, Middle, Last)				RICIA	N	18. MOTA	ER'S NAI		TE OF	_	RYLAN	D
BE C	S	SIDNEY RUI	FUS WATS	SON	ON CORA WHITLEY								
5	19a. INFORMANT'S NAME (Type/Print) LUCY A. W	ATSON	TSON 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1241 FRANCIS AVENUE ARBUTUS, MD 21227						7				
	20a. METNOD OF DISPOSITION 1 Secretaria 2 Cremation 3 Rem 4 Denation 5 Other (Specify)	oval from Stata	20b. PLACE, cemetery, cre	AND DATE C	FDISPOSIT	ION (No	ime of		05/95	20c. LOC		City or To	
	21. SIGNATURE OF PHERALISERVICE LIC	ENGÉE)		M PA	22. N	ÖÜÏ	ON P	ARK	FUNERA	AL HO			
_	ley C.	me	_						AVENU				MD 21229
rion	23. PART I. Enter the diseases, or shock, or heert fallure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate	s. Intrace DUE TO (b. Acute	se on aach ilna	ventrouence of	icula	r `	fibr	illa	tion	or respir	atory sr	rest,	Approximate Interval Between Onset and Death / hour
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST	d,	OR AS A CONSE										
¥ ا	PART II. Other algnificant condition					erlyin	g ceuse g	iven in l	Part I. 24	PERFORI		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDICAL	Metastatic	prostat	e car	cinc	ma		-		1	YES 2			COMPLETION OF CAUSE OF DEATH?
	DID TOBACCO USE CONTI	RIBUTE TO CAL		-			UNC	ERTAIN	N/A				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? t YES 2 NO	HOSPITAL:			OTHER:								
£	27. MANNER OF DEATN	1 Inpatient 2 I		28b. TIME		_	e 5 Re	eldence	6 Other (Sp 28d. DESCRI		Illey oo	OURER	
BY P	1 Natural 5 Pending Investigation	(Month, Da	y, Year)	INJI	JRY M	1 🗆 1	RK?	NO NO	Zed. DESCRI	BE HOW IN	JORY OC	CORED	
ETED	3 Suicide 8 Could not be detarmined	28a. PLACE OF building, e	INJURY — At ho etc. (Specify)	eme, farm, s	treet, factory	y, offic			28f. LOCATIO City or To	N (Street ar own, State)	nd Number	r or Rural R	outa Number,
COMPLE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSI (Check only one) 2 MEDICAL EXAMINE												and manner as stated,
	1994 SIGNATURE AND TITLE OF CERTIFIER	1					29c. LICE	NSE NUM	BER		29d. DAT	E SIONED	(Month, Day, Year)
2 .	SO NAME AND ADDRESS OF PERSON WHI	O COMPLETEO CAUS	E OF OEATH (ITE	M 27) (Type.	Print)		D.	226	648		> ()		30,1995
	/ JEROME I. SNYD	ER, M.D.	900 5			E.	BALT	rime	RE M	nD.	1/21	1229	
	JUL 0 7 1995	32 REGISTRAF	'S SENATURE								*		



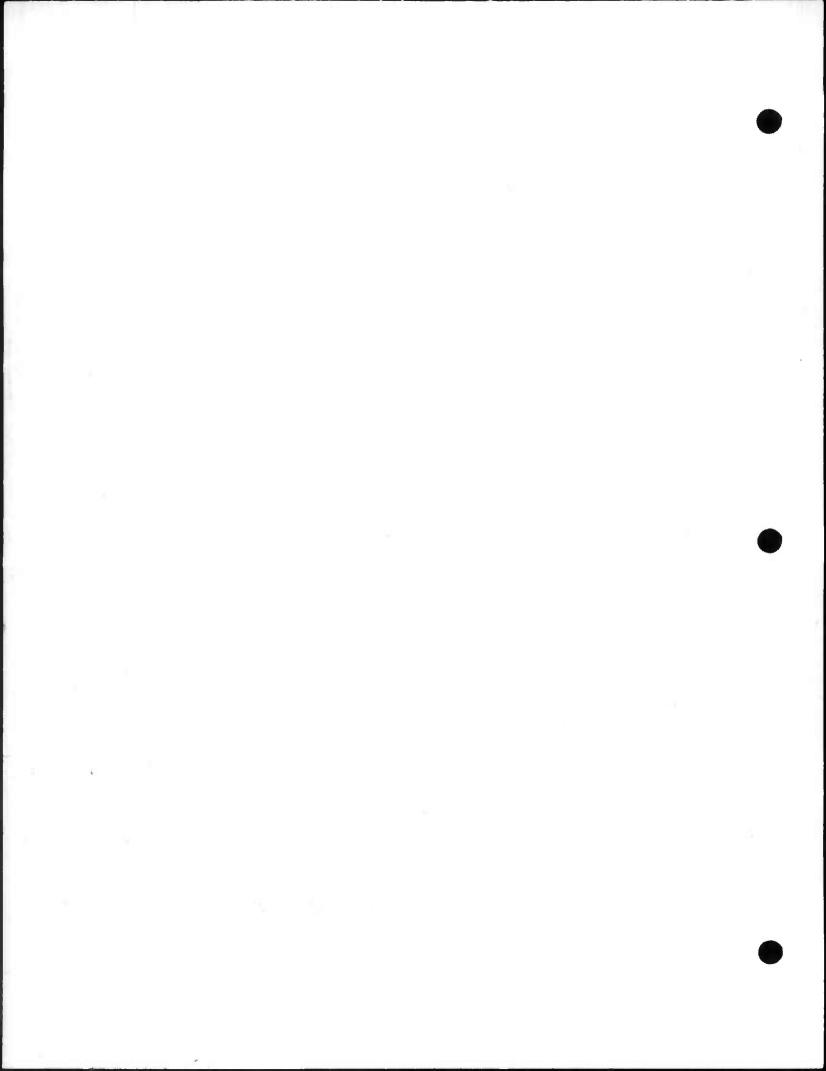


DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO.		
- 1	1. DECEDENT'S NAME (First, Middle, Lest) PHILLIP L.	WHITE				2. DATE OF DEATH	¥, 199	3. TIME OF DEATH 2024 Pm
	015 00 1651	SEX 6. AG	E (In yrs. lest birthday) 31 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH	64 BA	THPLACE (State or Foreign White)
TOR	9a. FACILITY NAME (# not institution, give street UNIVERSITY HOSE RESIDENCE OF DECEMENT		·.U		IMORE C		9c. COUNTY OF	n/a
DIRECTOR	10a. STATE 10b. COUNTY MARYLAND	n/a	18c. CIT	Y, TOWN OR LOCA BALTI				10d. INSIDE CITY LIMITS? 1 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 2110 BOLTON	STREET		10	2121	7	109. CITIZEN O	F WHAT COUNTRY?
В	11 MARITAL STATUS 12 Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YE	S 2 YMD	13. WAS DEC If yes, as 1 — YES	ENDENT OF HISPAN ecity Guban, Mexicar 2 NO Specify	IC ORIGIN? (Specify Yes n, Puerto Rican, atc.)	Bi	ACE — American Indian, lack, Whita, atc.
COMPLETED	15. DECEOENT'S EOUCATI (Specify only highest grade con Elementary/Secondary (0-12) 9	ON opleted) college (1-4 or 5+)	(Give kind of v	usual occupati work done during mo the retired.)	est of working	16b. KIND OF BUS	SINESS/INDUSTRY	
BE CON	17. FATHER'S NAME (First, Middle, Last) WILLIAM HARRI	S				ME (First, Middle, Malden EATRICE M	Surname) ILLER	
70	19a. INFORMANT'S NAME (Type/Print) JODELLE FERGU		19b. MAILING 359	ADDRESS (Street)	ANN ROAL	O, BALTIMO	n, State, Zip Code) RE, MAR'	YLAND21221
	20a METHOD OF DISPOSITION 1 Autrial 2 Cremation 3 Removal 4 Donation 5 Other (Specify)		ob. PLACE AND DATE (emetery, crematory or o	DEDISPOSITION (N.	ERY 7-		CATION — City of ANSDOWNE	Town, State E, MARYLAND
	21. SIGNATURE OF FUNERAL SERVICE LICENS				C. MARCH			
7	23. PART I. Enter the diseases, or comshock, or heart failure. List IMMEDIATE CAUSE (Final disease or condition resulting in death)	DUE TO (OR AS	each line.			a a cardiac or reapi	ratory arrest,	Approximate Interval Between Onset and Daath
CERTIFICATION	Sequentially list conditions, if sny, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		A CONSEQUENCE OF					
MEDICAL	PART II. Other significant conditions of					PERFOR	MED?	4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 PYES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	UTE TO CAUSE	26. PLACE OF DEAT		UNCERTAIN			
HYSI	1X XYES 2 □ NO 1 0	Inpetient 2 X ER/Ou	7 285 TIM	4 - Nursing Horr	e 5 Residence (B Other (Specify) 28d. OESCRIBE HOW II	NURY OCCURED	
B	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be	/ T	-65 206 RY — At home, farm, s	OM 1 .	RK? /ES 2 PNO	Subject 281. LOCATION (Street a	Sunged	from 74 Plas
COMPLETED	4 Homicide determined	building, atc. (Sc	esidence			OSI GCOI	ge St	Bullmore
OMPI	(Check only one) 2 M MEDICAL EXAMINER: O	it: To the best of my known the basis of examinet	wiedge, daath occurre lon and/or investigation	d at the time, date n, in my opinion, d	and place, and due t eath occured at the t	to the cause(a) and men	ner as stated. d dua to the cause	a(s) and menner as stated.
H	29b. SIGNATURE AND TITLE OF CERTIFIER	Gu	2		29c. LICENSE NUM	BER	29d. DATE SIGNI	ED (Month, Day, Year) 5,1995
2	30. NAME AND ADDRESS OF PERSON WHO DE	uler.	111 Per	n Stre		timore,		
	31. DATE FILEO (MONTY DO 1995	13 Manhane M	anthrill					

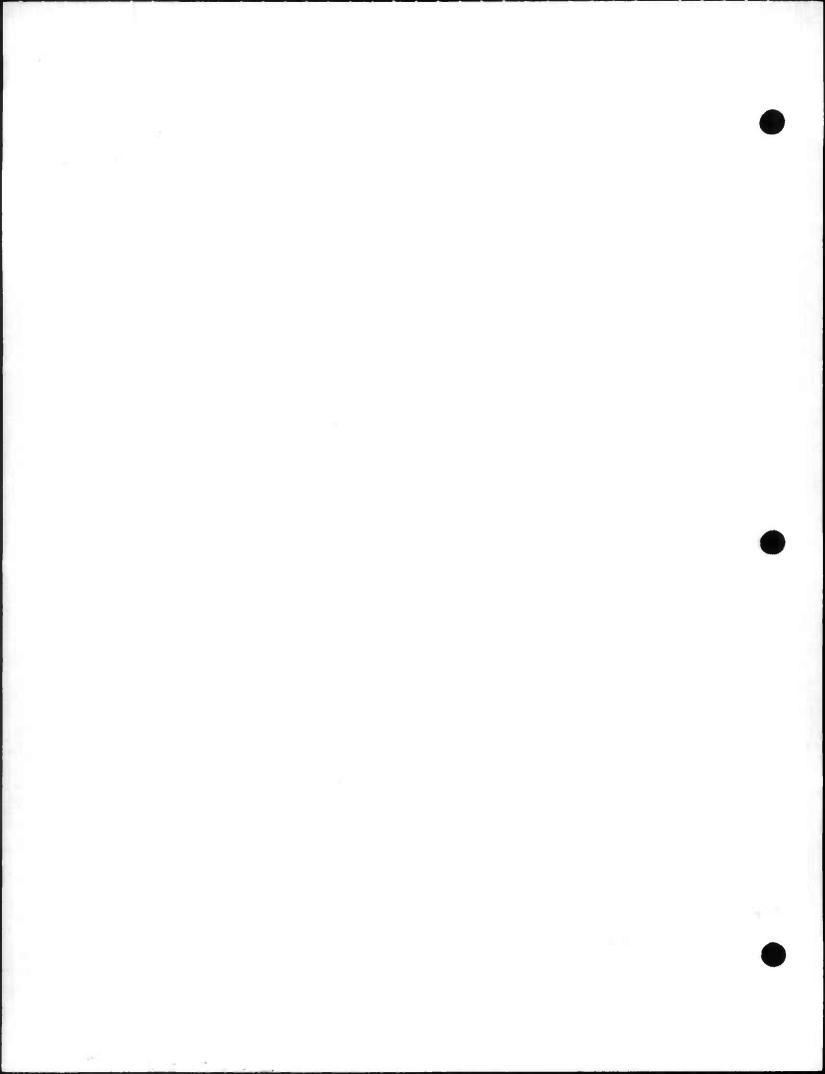


Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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	1 - FOR STATE REGISTRAR	STATE OF MARYLAN		ENT OF HEALTH AND	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)	CARL	WILS	WW.	2. DATE OF DEATH		3. TIME OF DEATH
		SEX 8. AGE (In y)		NOER 1 YEAR IF UNDER 24 HRS. THE DAYS HOUPE MIN.	7. DATE OF BIRTH (Month, Day, Year)	1.0	BIRTHPLACE (State or Foreign Country) BALTIMORE, NiD
FOR	9a. FACILITY NAME (If not institution, give stree VA Mudicul Guide RESIDENCE OF DECEDENT	and number)		BALTIMURE 4	EATN	9c. COUNTY	
DIRECTOR	10a. STATE 10b. COUNTY	n/a	10c. CITY, TO	WN OR LOCATION			10d. INSIDE CITY
	100. STREET AND NUMBER 1601 E. EAGER			BALTIMORE 101. ZIP CODE	0.5		1 TYES 2 NO
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married	2. WAS DECEDENT EVER IN U.S FORCES? X YES 2 IF YES, GIVE WAR OR DATES	! □NO	212 13. WAS DECENDENT OF NISPA If yes, specify Cuban, Maxici 1 YES 2 NO Specify	NIC ORIGIN? (Specify Yean, Puerto Rican, etc.)	UNITE 8 of No — 14.	RACE — American Indian, Black, White, etc.
	15. DECEDENT'S EDUCAT (Specify only highest grade cor	5-5-42/ 9-27- TON 160 Inpleted) 160	. DECEDENT'S USU	AL OCCUPATION fone during most of working	16b. KIND OF BU	SINESS/INDUS	BLACK
COMPLETED	6 TH	College [1-4 or 5+)	Ille. Do NOT use reti	mployed OWNER	GR	OCERY	STORE
BE CO	17. FATHER'S NAME (First, Middle, Last) CHARLES MACK	WILSON		18. MOTHER'S NA	AME (First, Middle, Maiden ELVIRA	Surname) HOLMES	
10	19a. INFORMANT'S NAME (Type/Print) PATRICIA WILS	SON	196. MAILING ADD 3456	RESS (Street and Number or Rural VARGAS CIF	ROLE, APT.1		
	20e. METHOD OF DISPOSITION PLABurial 2 Cremetion 3 Remova 4 Donation 5 Other (Specify)	I from State 20b.PL.	ACEAND DATE OF DIS	SPOSITION (Name of	DATE 20c. LO		or Town, Stata MILLS, MD
	21. SIGNATURE OF FUNERAL SERVICE LICENS		et l	22. NAME AND ADDRESS OF FA	CILITY		IORTH AVENUE
CERTIFICATION	23. PART I. Enter the diseases, or come ahock, or heart sellure. List immediate cause. Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO JOR AS A CO	POSTA NSEQUENCE OF):	Tac Calcivi		iratory arrest	, Approximate interval Between Onset and Death
	that initiated events resulting in death) LAST DART II. Other significent conditions of	DUE TO JOR AS A CO		a underbulen en en eleve le	Part I. 24s. WAS AN		
PHYSICIAN: MEDICAL			ot resolving in the	a underlying cause given in	PERFOI	RMED?	24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 \(\sqrt{1}\) NO
HAN:	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL	28. 1	PLACE OF DEATH (CF		N		
IVSIC		OSPITAL: Impetiant 2 ER/Outpatier 28s. DATE OF INJURY		HER: Nursing Home 5 Residence			
ВУ РІ	1 Setural 5 Pending Investigation	(Month, Day, Year)	INJURY	WORK?	28d. DEŞCRIBE NOW I	NJURY OCCUR	ED
	3 Suicide 8 Could not be 4 Homicide detarmined	28e. PLACE OF INJURY — A building, etc. (Specify)	At home, farm, street,	factory, office	28f. LOCATION (Street City or Town, State)	and Number or F	Rural Route Number,
COMPLETED				the time, date and place, and due			nuse(s) end manner as stated.
BE 0	29b. SIGNATURE AND TITLE OF CERTIFIER	1:0		29c, LICENSE NUI	MBER	29d. DATE SI	GNED (Month, Day, Year)
5	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEATH	JITEM 27) (Type Print)	IMKOF	187	Juli	14,1995
	3315 PINK	NEY RU	MAD	BALTIM	orz		
	JUL 07 1995 Jalia	2. REGISTRAR'S SIGNATUR	RE				

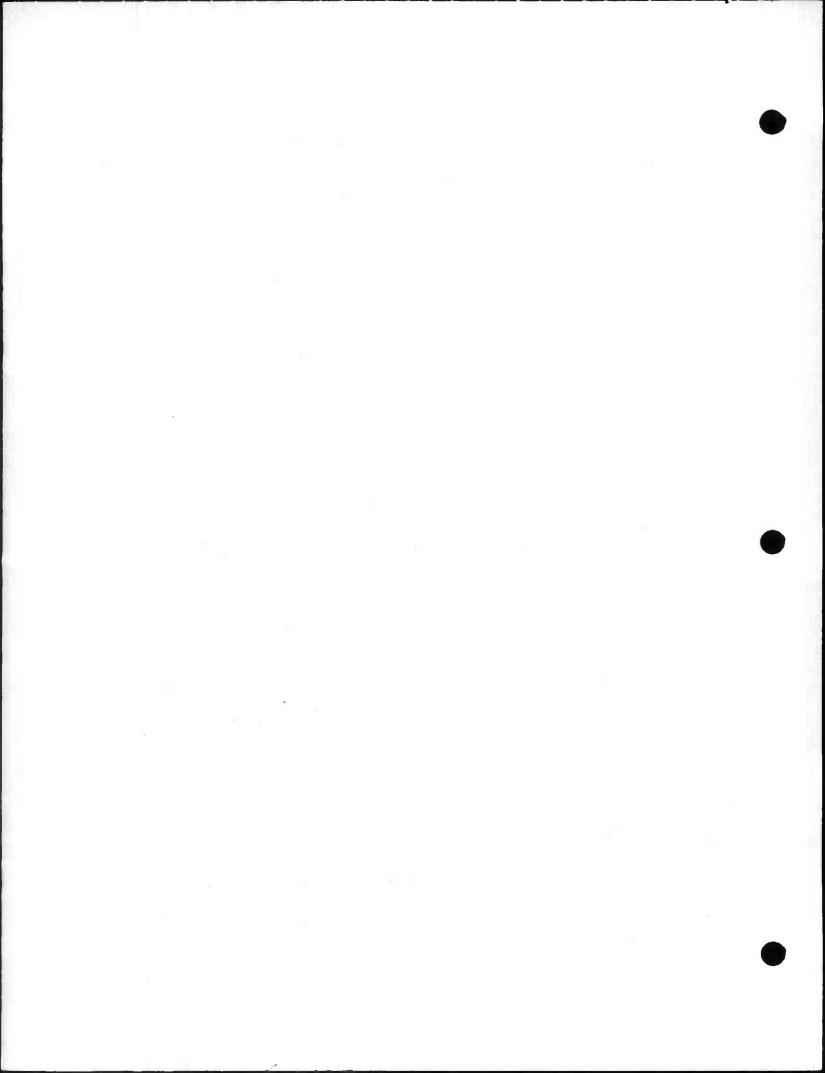


DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremating without the tendent of them 28 shows any injury, or other traumatic event, the property of	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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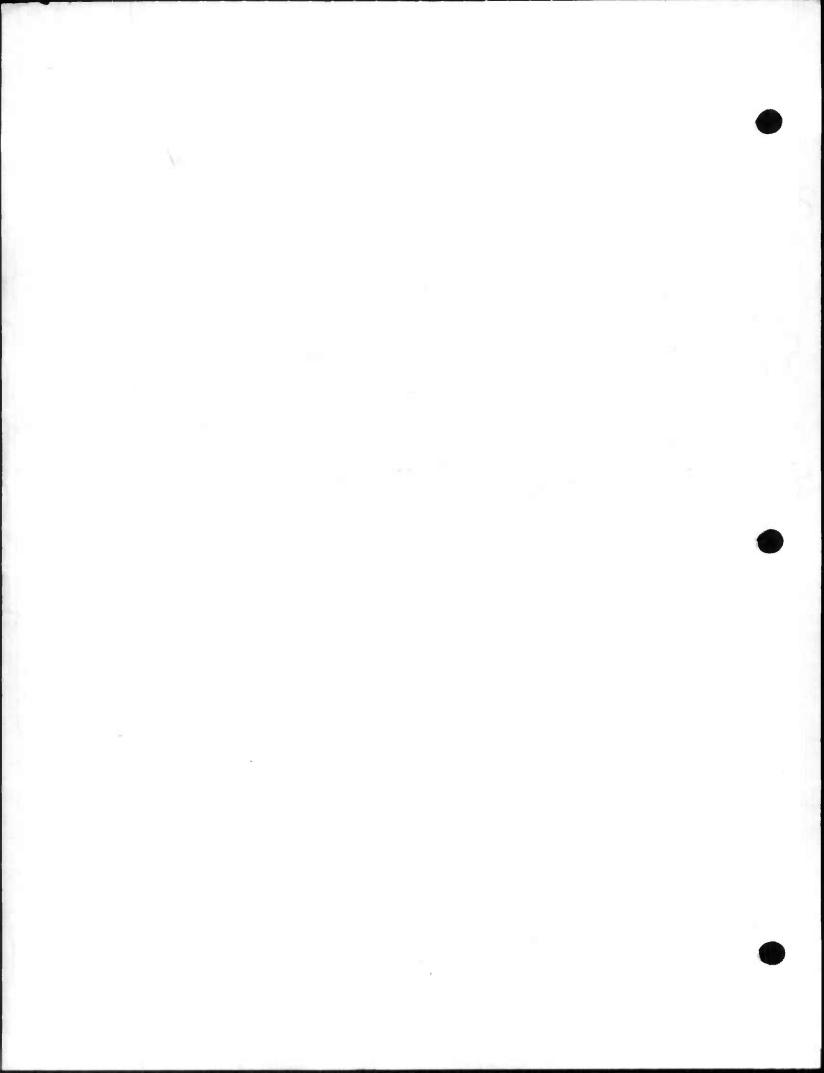
1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	AEGIST NAM		CENTIFI	CALE OF	DEALL	REG. NO),	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	MY	YEAR 3. TIME OF DEATH
	WIL	WHITING				1, 199		
	4. SOCIAL SECURITY NUMBER		. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8	BIRTHPLACE (State or Foreign Country)
	212-58-0347	1 <u>√</u> M 2 □ F	44 YAS.			DEC.23,	1950	BALTIMORE. MD
œ	9e. FACILITY NAME (If not institution, give a	ŕ		9b. CITY, TOWN (R LOCATION OF D	EATH	9c. COUNT	Y OF DEATH
DIRECTOR	233	6 E. EAG	GER STREET	BAL	TIMORE	CITY		n/a
୍ଷ	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	1	10c CITY	TOWN OR LOCAT	ION			
E E	MARYLAND n/a			BAL			10d. INSIDE CITY LIMITS?	
	10e. STREET AND NUMBER	1/ α				1 🔀 XES 2 🗆		
FUNERAL			R STREET	101	2120	E		N OF WHAT COUNTRY?
Z	.11, MARITAL STATUS	12. WAS DECEDENT		40 000 000				ED S TATES
	↑ Never Married 2 ☐ Merried	FORCES? 1	YES 2 NO	If yes, sp	city Cuban, Mexico	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)	8 or No — 14	Black, White, etc.
B≺	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES	1 🗆 YES	2 NO Specif	fy:		Specify: BLACK
입	15. DECEDENT'S EDU		16a. DECEDENT'S U	ISUAL OCCUPATION	IN	16b. KIND OF BU	SINESS/INDUS	
<u> </u>	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Give kind of we	ork done during mo retired.)	st of working	00-1000	-,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
₫	12 TH	_	SANI	TATION	WORKER	CITY	of B	ALTIMORE
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Middle, Melden	Sumame)	
BEC	MACON JON	ES			ANN	GREEN	,	
	19s. INFORMANT'S NAME (Type/Frint)		19b. MAILING	ADDRESS (Street e		Route Number, City or Tow	n, Stete, Zip Co	ode)
위	TAVONIA	WHITING	113					E. MD 21217
- 1	20s. METHOD OF DISPOSITION		Ob. PLACE AND DATE OF	F DISPOSITION (Na	me of	DATE 20c. LC	CATION — CIT	y or Town, State
- 1	7 ☐ Burtal 2 ☐ Cremation 3 ☐ Rams 4 ☐ Donation 5 ☐ Other (\$pecify)	over from State	VOSHELL N	MEMORIAL	GARDEI		JNDALK	
- 1	21. SIGNATURE OF FUNERAL SERVICE LIC	ENIEE /	1		D ADDRESS OF FA			,
	· Albert	641		WM.	C. MAR	CH FH110	L E.	NORTH AVENUE
CERTIFICATION	23. PART I. Effer the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):							
	PART II. Other significant condition	contributing to de	eeth but not resulting in	the underlying	ceuse given in			24b. WERE AUTOPSY FINDINGS
DICAL	Alcoholism					PERFOR		AMILABLE PRIOR TO COMPLETION OF CAUSE
Σ							7-5	OF DEATH?
z I	DID TOBACCO USE CONTR	RIBUTE TO CAUS	SE OF DEATH YES	□ NO □	UNCERTAIL	X		
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH					
2	1 TYES 2X NO	HOSPITAL:		OTHER: Nursing Home	Residence	6 Other (Specify)		
BY PHYSICIAN:	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF IN. (Month, Day,		RY WO	IRY AT RK?	26d. DEŞCRIBE HOW I	NJURY OCCUP	ED
3 Suicide 6 Could not be determined 266. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 266. PLACE OF INJURY — At home, ferm, street, factory, office City or Town, Stete)						Rural Route Number,		
COMPLE			knowledge, death occurred					
3	2 MEDICAL EXAMINE	1: On the baels of exam	ninstion end/or investigation,	In my opinion, de	sth occured at the	time, data end piece, en	d due to the c	euse(s) and menner se stated.
K	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI	WBER	29d. DATE S	IGNED (Month, Day, Year)
5	u where		patol attende		D2330=	t mo	→ 7-1	7195
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH (ITEM 27) (Type, F	Print)				-
	MAURA MGU		3 0001	AST EN	tyck s	TREET	BALO	mp 21252
	JUL 07 1995 Ja	L. HERITAR	A GN TUTE					



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FOR STATE REGISTRAR CERTIFICATE OF DEATH BEG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH 9:55 P 02 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign -50-2142 49 YRS HOURS MIN. Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give str System 9b. CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH University Mary of Baltimore DIRECTOR land RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND TIMORE YES 2 NO permit. FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2121 WHATC been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit and Mental Hygiene prior to burial, cremation, or removal. SA retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No. H was, snecify Cuben, Mexican, Puerto Rican, etc.) WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black White, etc. 1 Never Married 2 Married If yes, specify Cube BY Specify 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION ecily only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) ary/Secondary (0-12) College (1-4 or 5+) 6++ GRADE -ABORER once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maid to HANSIEL Lou WILLIAM BE WHEATLEV notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 HOMAS TIMORE. Page 6 may be 9 METHOD OF DISPOSITION
Burlel 2 Cremation 3 Rem 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must CEMETERY 7-6-☐ Donation 6 ☐ Other (Specify) _ BALTIMORE. medical examiner 21. SIGNATURE OF FUNERAL RESIVICE LICENSES 22. NAME AND ADDRESS OF F BROWN JR. FUNERAL HOME, P.A. hours after death. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223 PART L'Errer tha diseases, or complications that caused tha death. Do not antar tha mode of dying, such as cardiac or respiretory arrest, Approximate ick, or hasrt failure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final Onset and Dasth the disease or condition Netastatu within , event, 1 resulting in death) DUE TO (OR AS A CONSEQUENCE OF) executed unknown traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate certificate be cause. Enter UNDERLYING CAUSE (Disesse or injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 Injury. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? Smo Ker any 1 TES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO INCERTAIN SO PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Hem DIRECTOR: After this certificate I hours after death with the State 1 YES 2 NO HOSPITAL:
1 (Alignetism 2 - ER/Outpetient 3 - DOA OTHER: OR ATTENDING PHYSICIAN: 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked. 1 Natural 5 Pending Investigation М 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 40 6 6 Could not be 4 🗌 Homicide 28 determined COMPLET Tem 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. TO THE HOSPITAL O
TO THE FUNERAL DI
DE filed within 72 ho
IMPORTANT: If ite MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. AND TITLE OF CERTIFIER 29c LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, 0 95 2 30 NAME AND ADD SE OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ghiorz Ba 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE JUL 0 71995



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

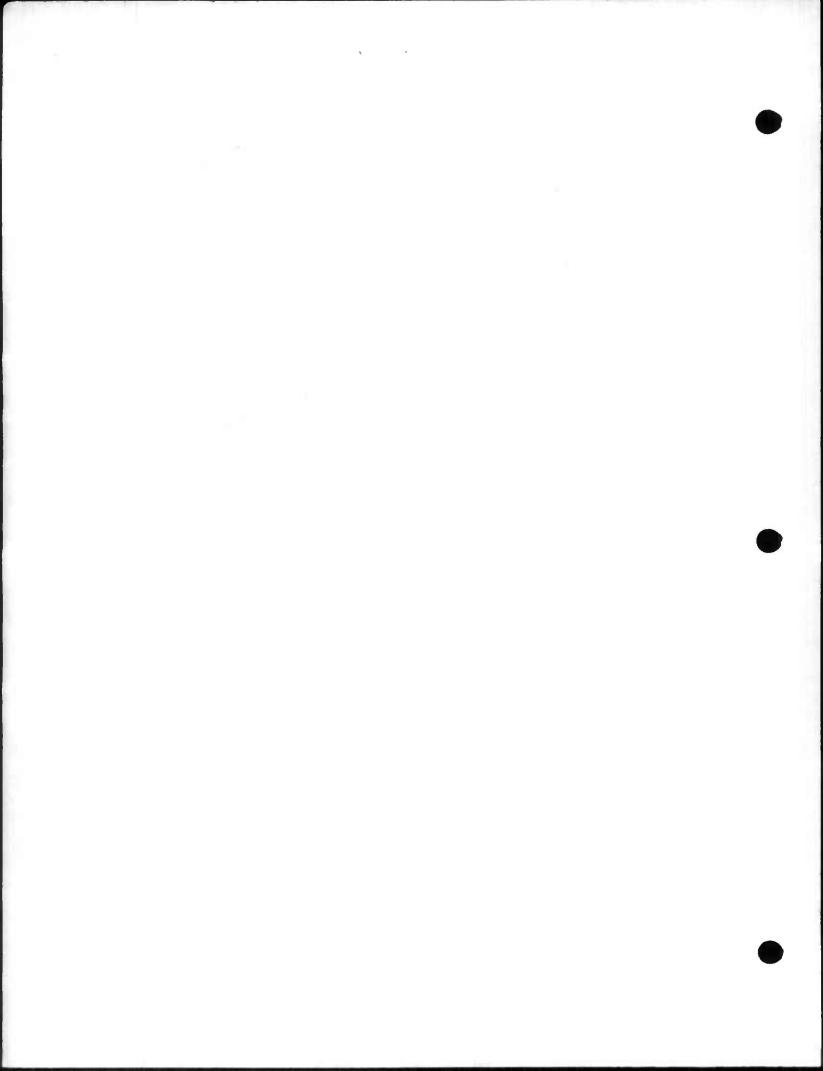
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTA	L HYGIENE
 CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPART	MENT OF H	IEALTH AND	MENTAL HYGI				
	1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEAT	V		TIME OF DEA	TN			
	WALLACE LEE	ANDRE	ANDREWS				JUNE 16,1995 090			A M
	4. SOCIAL SECURITY NUMBER	i. SEX 6. AGE (II		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH			Bethe	omign
	Z77 J1 J200	X M ² □ F 29	YRS.	NONTHS DAYS	HOURS MIN.	October &	3, 1965	Nort	h Caro	lina
	9a. FACILITY NAME (If not institution, give street	et and number)		9b. CITY, TOWN	OR LOCATION OF	DEATN		TY OF DEAT		711114
OR	ST.MARYS CITY	RT.#5		St. Ma	rys		ST	. MAR	YS	
띮	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c CITY	TOWN OR LOCA	ION			140		
DIR	Maryland St. Mar	100. 011, 10			ngton Park				d. INSIDE CIT LIMITS?	
7	10e. STREET AND NUMBER				101. ZIP CODE					
FUNERAL DIRECTOR	Route 1, Box 95W				20653		Unit	ed St	Amei	ica
S		2. WAS DECEDENT EVER IN		13. WAS DEC	ENDENT OF HISP	ANIC ORIGIN? (Specify			American Ind	
BY F	1 Never Married 2XXMarried 3 Widowed 4 Divorced	FORCES? 1 TYES			ecify Cuban, Maxis 2 NO Spec	can, Puerto Rican, etc.		Black, W Specify:	hita, atc.	
	2 1/ 42 - 3/1929							Black		
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con	TION mpleted)	(Give kind of wo	rk done during mo	ON st of working	16b. KIND OF	BUSINESS/INDU	STRY		
2	Elementary/Secondary (0-12)	College (1-4 or 5+)	lile. Do NOT use Jani:			Cloom	lac Com			
MC	17. FATNER'S NAME (First, Middle, Last)		Jani	LOI	40 1007110010 1		ing Com	pany		
	William H. Andrews	ı			the same and the	AME (First, Middle, Mai Latham	den Sumame)			
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDBESS (Street o		I Route Number, City or	Paus Chata Fin /	Code	27871	
2	Brenda Jackson					ersonvil				
	20a. METNOD OF DISPOSITION	206.1	PLACE AND DATE OF					-		
	1 X Burial 2 Cremation 3 Remova 4 Donation 8 Other (Specify)		drews Cer			1995 No	LOCATION - C	ton,	0	- }
	21. SIGNATURE OF FUNERAL SERVICE LICEN			22. NAME A	D ADDRESS OF F	ACILITY			<u>a</u>	
	Hound	1 Cara	- 4			neral Home Roberson		NG 2	7071	- 1
	23. PART I. Enter the diseases, or con	nplications that ceused	the daath. Do no	t enter the mo	da of dving, au	ch as cerdiac or re	apiratory arre	INC Z	Approxim	nata .
	ahock, or heart fellure. Lis	t only one cause on as	ch Ilna.				-p		Interval E Onset an	etween
	disease or condition							Oriset an	u Death	
	DUE TO (OR AS A CONSEQUENCE OF):									
z	Sequentially list conditions, b.								[
E	If any, leeding to immediate out to (or as a consequence of):									
2	CAUSE (Disease or injury C.							ļ 		
Ē	that initiated eventa resulting in death) LAST	OUE TO (OR AS A C	CONSEQUENCE OF):							
CERTIFICATION	d									
AL	PART II. Other algolificant conditions of	ontributing to deeth bu	t not reaulting in	the underlying	ceuse given is		AN AUTOPSY FORMED?		RE AUTOPSY F	
음						7.80	2 NO	CO	MPLETION DF	CAUSE
ME									YES 2	NO
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIB				UNCERTA	N 🗆				
호	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	B. PLACE OF DEATH	(Check only one)						- 1
ΙΥS	XIX YES 2 NO 1 27. MANNER OF DEATN	☐ Inpatient 2 ☐ ER/Outpat	tient 3 DOA 4	☐ Nursing Nom	5 🗆 Residence	117 177	ROADV			
	1 Netural 5 Pending	28a. DATE OF INJURY (Month! Day, Year)	28b. TIME (WO WO	RK?	28d. DESCRIBE NO		RED ,	- // -	
B	2 Accident Investigation 3 Suicide & Could not be	28a. PLACE OF INJURY -	S 1543			Oriver -	0.00	auto	colli3	100
	4 Homicide 6 Could not be	building, atc. (Specific	1)	set, rectory, ornici	1	281. LOCATION (Str. City or Town, St	afe)			- 1
	29a. CERTIFIER 1 CERTIFYING PHYSICIA		way			, , ,		we	٥,	
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: (N: To the best of my knowled On the basis of examination							d manner aa s	tated.
	29b. SIGNATURE AND TITLE OF CERTIFIER	19/11			29c. LICENSE NU				nth, Day, Year)	
BE.		CAL			O.C.M.				L6,19	95
2	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETEO CAUSE OF DEAT	H (ITEM 27) (Type, P.	rint)					-	
	David R Fo	wer 1	11 Penr	Stree	et, Bai	ltimore,	Mary	Land	2120	1
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT								
	JUN 21 1995 Jahr	Davidson Reda	Ц							

78 Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number DIRECTOR Physicians Memorial Hospital RESIDENCE OF DECEDENT 10b. COUNT 10e. STATE Maryland Charles permit, 10e. STREET AND NUMBER FUNERAL 9530 Bel Alton-Newtown Road n and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit to burial, cremation, or removal. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Merried BY Mydowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Spe entary/Secondary (0-12) College (1-4 or 5+) Homemaker 17. FATHER'S NAME (First, Middle, Last) Lewis Henry Cargill BE notified 19e. INFORMANT'S NAME (Type/Print) 2 Jane Moreland pe 20a METHOD OF DISPOSITION
1 X Burlel 2 Cremetion 3 Removal from State must ☐ Donation 5 ☐ Other (Specify). examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00174 hours after death. medical shock, or haert failure. Liet only ona cause on each line. **IMMEDIATE CAUSE (Final** 事 disease or condition_ MYOCARDIAL event, resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): the death certificate be executed traumatic CONGESTIVE CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): signed by the attending physician Health and Mental Hygiene prior to if any, laading to immediate cause. Enter UNDERLYING A SPIRATION CAUSE (Diseese Dr injury other DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST 0 MEDICAL апу has been : PHYSICIAN: OR ATTENDING PHYSICIAN: The law or DIRECTOR, After this certificate has be hours after death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? Item HOSPITAL: OTHER: 1 YES 2 NO 1 Danpatient 2 ER/Outpatient 3 DOA 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY marked, 1 Natural 5 Pending Investigation м BY 2 Accident 3 Suicide ETED 8 Could not be 28 4 Homicide 29e. CERTIFIER COMPL HOSPITAL (FUNERAL D within 72 ha (Check only one) = TO THE HOSPITY
TO THE FUNERA
De filed within 7 29b. SIGNATURE AND TITLE OF CERTIFIER BE 2

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE . STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 YEAR Martha June 24 Elizabeth Alvev 04:20 P: 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign e 29,1916 219-48-5785 1 M 2 X F June Maryland 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH LaPlata Charles 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Bel Alton 1 YES 2 NO 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20611 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE --- American Indian, Black, White, etc. Spectly White 18e. DECEOENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b, KIND OF BUSINESS/INDUSTRY Home 18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Elizabeth Lucas 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5750 Sixes Road, Prince Fredrick, Md. 20678 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE United Methodist Cem 6/27 Dentsville, Maryland 22. NAME AND ADDRESS OF FACILITY Arehart-Echols Funeral Home, P.O. Box 567 La Plata, MD 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiretory strest, Approximats Interval Between Onset and Death INFARCTION FEW JAY (HEAR? FAILIGNE FEW DAYS FEW DATS PN EUMONIA PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 26. PLACE OF DEATH (Check only one) g Home 5 - Residence 6 - Other (Specify) 28c. INJURY AT WORK? 28d, OESCRIBE HOW INJURY OCCURED 1 YES 2 NO 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, Stete) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 2 MEDICAL EXAMINER: On the besie of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D-21173 125791 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Niran P. Sharma MD 11345Pembrooke Square Suite #104 Waldorf, Md. 20603 32. REGISTRAR'S SIGNATURE 1995



Laron Locke

Julia d'Audion harlall

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BALLIMORE, MARYLAND 21215-0020	res that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	igned by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per	
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CURDS, F.O. BOX 88760	res t	gnec	Atth
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR Teresa Dawn Ackerman June 1995 1520 0 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year 5 SEY 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 1 🗌 M 2 😾 F 14 430-51-7445 198¢ Sept. 19, Arkansas Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 2106 Genema Place Bel Air Harford 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland 1 YES 2 1 NO Harford **Edgewood** FUNERAL 10e. STREET AND NUMBER 10f ZIR CODE 10g. CITIZEN OF WHAT COUNTRY? 617 Boxelder Drive 21040 USA 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ★ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or Noif yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried 1 TES 2 NO Specify: BY Specify: 3 Widowed 4 Divorced white ETED. 18. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 166. KIND OF BUSINESS/INDUSTRY (Specifi Elementary/Secondery (0-12) College (1-4 or 5 +) COMPL 8 student student once. 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname notified at BE James Thomas Ackerman Donna Louise Howard 194. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 Donna L. McLaughlin 617 Boxelder Drive, Edgewood, Maryland must be 20a. METHOD OF DISPOSITION

1 Suriel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE 1 Donation 8 Other (Specify) Highview Memorial Gardens 6/27/\$5 Fallston, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. medical 23. PART I. Entay the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Interval Retween IMMEDIATE CAUSE (Final Onset and Death the disease or condition event, resulting in death) DUE TO OR AS A CONSPOUENCE OF traumatic CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other 1 OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Injury, or PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? any 1 YES 2 NO shows DIVISION OF VITAL RE 1 TYES 2 NO been s DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has b Dept. OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h EXAMINER? HOSPITAL OTHER: 1 Inpatient 2 ER/Outp 4 Nursing Home 5 Residence Other (Specify) at 0 27. MANNER OF DEATH TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY_OCCURED this (marked. 1 Natural 22/9 5 Pending ell M 1 YES 2 NO 30 B 01 After 1 2 Accident PLACE OF INJURY -building, etc. (Specify) m, etreet, tectory, office 28f. LOCATION (Street and Number or Bural Boute Numb 99 8 Could not be DIRECTOR: / 1Ay Grah 4 Homicide 1 determined 28 LODD 20 GENEVE Ш COMPL 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and ma HOSPITAL (FUNERAL D WITHIN 72 h 200 TO THE HOSPITA TO THE FUNERAL De filed within 72 IMPORTANT: II 2 X MEDICAL EXAMINER: OF in my opinion, death occured at the time, date end place, end due to the cause(e) end manner ee stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d, DATE SIGNEO (Month, Day, Year) O.C.M.E June 23 1995 9 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

111 Penn Street, Baltimore, Maryland

DIVISION OF VITAL RECORDS, P.O. BOX 68760

G PHYS	ECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should a safter death with the State Dept. of Health and Mental Hyplene prior to burial, cremation, or removal.	28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN	TO THE FUNERAL DIRECTOR: After this certific be filed within 72 hours after death with the S	IMPORTANT: 16 Item 28 is marked, or i

			95	20583			
1 - STATE	STATE OF MARYLAND / DEPART						
REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)	CERTIFIC	CATE OF DEATH	REG. NO.	3. TIME OF DEATN			
MAGGIR 1	M. AYO	mwood	TUNE 24.199	YEAR 1310			
4. SOCIAL SECURITY NUMBER		IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTN (Month, Day, Year)	8. BIRTNPLACE (State or Foreign Country)			
218-20-1401	YRS.		6-17-1924	md.			
9e. FACILITY NAME (If not institution, give st		B. CITY, TOWN OR LOCATION OF I		ITY OF DEATH			
PENINSULA REGIONA	L MEDICAL CENTER	SALISBURY		VICOMICO			
PENINSULA REGIONA RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	4	TOWN OR LOCATION		10d. INSIDE CITY LIMITS?			
	omkrsel fr	INCESS HI	NE	1 TES 2 P NO			
10. STREET AND NUMBER P.O. BOX 11. MARITAL STATUS	171	101. ZtP CODE Z 185	10g. CITIZ	ZEN OF WHAT COUNTRY?			
11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED	_	ANIC ORIGIN? (Specify Yes or No	14. RACE American Indian.			
3 Widowed 4 Divorced	FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	If yes, specify Cuban, Mexic 1 ☐ YES 2 Ø NO Spec	en, Puerto Rican, etc.)	Black, White, etc. Specify: B/ACK			
15. OECEDENT'S EOUC (Specify only highest grade	completed) (Give kind of wor	k done during most of working	16b. KINO OF BUSINESS/INDI	USTRY			
(Specify only highest grade Elementary/Secondary (0-12) 17. FATHER'S NAME (First, Middle, Last)	College (1-4 or 5+)	/	Domes	tic			
17. FATHER'S NAME (First, Middle, Last)	<i>F-M</i>	18. MOTNER'S N	AME (First, Middle, Maiden Surname)				
Ernest C	hristopher	m	Ary Wright	4			
19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
HIVIN J. Hrmwood P.D. BOX 471 Princess HAME Md. 21853							
20a. MPTNOD OF DISPOSITION 1 Devial 2 Cremetton 3 Remo	val from State 20b. PLACE AND DATE OF cametacy, crematory or other		7 OATE 20c. LOCATION - C	City or Town, State			
4 Donation 5 Other (Specify)	ENSEE	2. NAME AND ADDRESS OF	1 193 WEST 1	.O. Md.			
PX/1/	-511		1 1 Pr	incess Hinn			
23. PART I Enter the diseases or c	omplications that caused the death. Do not	30639 HAM		md. 21853			
snock, at weary tellure.	list only one ceuse on each line.	enter the mode of dying, su	on es osrdied or respiratory erre	Interval Between			
IMMEDIATE CAUSE (Finel disease or condition	Acute Ante	and Maria	rdial Infarct	Onset and Deat			
resulting in death)	DUE TO (OR AS A CONSEQUENCE OF):	Tion regola	raid Intales	In Pana			
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Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):						
CAUSE (Disesse or injury that initiated events	OUE TO (OR AS A CONSEQUENCE OF):						
resulting in death) LAST	(
	contributing to death but not resulting in	the underlying cause given is	Part I. 24s. WAS AN AUTOPSY	24b. WERE AUTOPSY FINDING			
			PERFORMEO?	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
			1 _ YES 2 _ NO	DF DEATH?			
DID TOBACCO USE CONTR	IBUTE TO CAUSE OF DEATH YES	□ NO □ UNCERTA	N 🗆				
DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN	26. PLACE OF DEATH HOSPITAL:	(Check only one)					
1 YES 2 NO	1 Inpatient 2 ER/Outpatient 3 DOA 4	☐ Nursing Nome 5 ☐ Residence					
III 1 3C Neturel 5 Pending	28e. DATE OF INJURY (Month, Day, Year) 28b. TIME (INJUR		26d. DESCRIBE NOW INJURY OCC	JRED			
2 Accident Investigation 3 Suicide 6 Could not be	26e. PLACE OF INJURY At home, term, stre		28f. LOCATION (Street and Number of	or Rural Route Number,			
4 Homicide determined	building, etc. (Specify)		City or Town, State)				
29e. CERTIFIER (Check only One) 1 CERTIFYING PNYSIC DISCOURSE TO MEDICAL EXAMINER	SIAN: To the best of my knowledge, death occurred a	at the time, date end place, end du	e to the cause(e) end manner as state	d.			
0700) 2 MEDICAL EXAMINER	: On the beele of examination end/or investigation,						
296. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NU	IMBER 29d. OATE	SIGNEO (Month, Day, Year)			
X a h Cal		1001-		12595			

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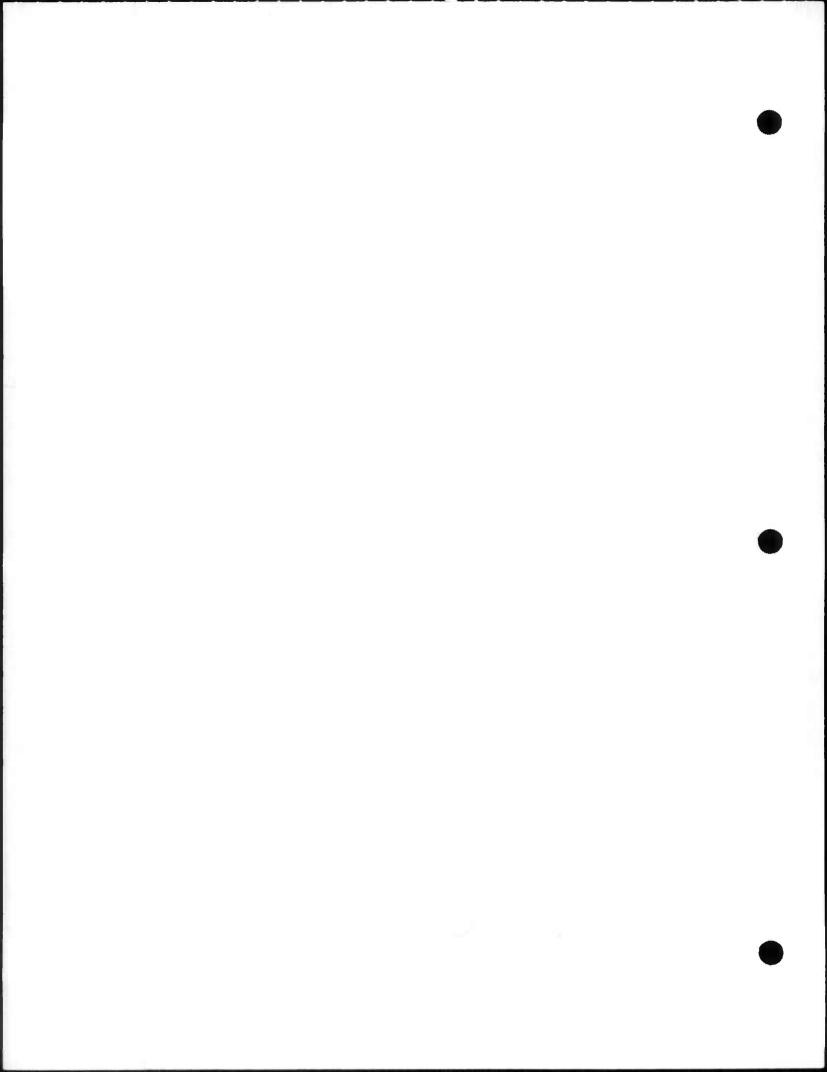
FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF CEATH 2:45 PM STANLEY ELSTE BETTS Tune 1995 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. OATE OF BIRTH 6. BIRTHPLACE (State or Foreign (Month, Day, Year) July 10 1912 DAYS HOURS 214-07-8539 KX M 2 YRS. Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Cambridge Dorchester General Hospital Dorchester RECTOR permit. Pages 1, 2, 3 RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Dorchester Cambridge 1x X YES 2 □ NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? U.S.A. 520 Glenburn Ave. signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit Health and Mental Hygiene prior to bunial, cremation, or removal. 21613 Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—II yea, specify Cuban, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indien, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 27 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married 1 YES 2 XNO Specify: BY Specify: white 3 🗓 Widowed 4 🗌 Divorced ED 15. DECEDENT'S EDUCATION 16a, DECEDENT'S USUAL OCCUPATION 16b, KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) during most of working (Give kind of work done life. Do NOT use retired.) COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) 10 auto mechanic automobile dealer notified at once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Columbus Christopher Betts Ida Elste BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 9 James E. Wilson 4219 Webster Rd., Havre de Grace MD 21078 pe 20s. METHOD OF DISPOSITION

KIX Burlel 2 Cremellon 3 Removal from State
4 Donellon 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State must Dorchester Memorial Park 6/23 Cambridge Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St., Cambridge MD 21613 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, Approximate ahock, or heart fallure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final **Onset and Death** the disease or condition Respiratory F
DUE TO (OR AS A CONSCOUENCE OF): event, 1 reaulting in death) or other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING Preumonid CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST any injury, PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL Acute enterocolitis COMPLETION OF CAUSE 1 - YES 2 -NO OF DEATH? 1 YES 2 NO this certificate has been it with the State Dept. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO $oxed{oxedge}$ Uncertain \square PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OR ATTENDING PHYSICIAN: The **EXAMINER?** HOSPITAL: OTHER: 1 | YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED is marked, 1 Natural DIRECTOR: After the hours after death w М 1 YES 2 NO В 2 Accident 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Yown, State) 6 Could not be COMPLETED 28 4 Homicide 29e. CERTIFIER (Check ank) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. FUNERAL (= TO THE HOSPITA
TO THE FUNERA
DE filed within 72
IMPORTANT: 1 2 _ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 8 28 ► June 20,1950 2 30. NAME AND ADDRESS OF PETSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Maclaughlin, Edmund M.D. 4 Aurora Street Cambridge, MD 21613 31. DATE FILED (Month, Day, M REGISTRAN'S SIGNATURE

DIVISION OF VITAL

BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriatureness nermin Pages 1.2 a should	or removal.	medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within ser hours after death. Page 6 may be retained by the hospital or attending physician,	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely file	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Lest) Dorotl	ny Virginia	BAKER			2. DATE OF DEATH MONTH 24,		YEAR 1	TIME OF DEATH 1:17 AM M
		1 🗆 M 2 📉 F	75 YRS. MONTHS DAYS HOURS MIN.			June 4, 1920 Maryl		and	
LOR	Frederick Memoria	99. FACILITY NAME (If not Institution, give street end number) Frederick Memorial Hospital 9b. CITY, TOWN OR LOCATION OF DE Frederick					eath 9c. COUNTY OF DEATH Frederick		
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE Maryland Frede	ty 10c. CITY, TOWN OR LOCATION derick Frederick						od. INSIDE CITY LIMITS? X YES 2 NO	
FUNERAL	10a STREET AND NUMBER 806 East Sout	ch Street		101	21701		U.S		AT COUNTRY?
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR DO	2 X NO	If yes, sp	ENDENT OF HISPAN Icity Cuban, Mexica 2000 NO Specifi	HiC ORIGIN? (Specify Yearn, Puerto Rican, atc.)	or No- 1	Black, W	American Indian, White, atc.
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	ATION ompleted) College (1-4 or 5+)	(Give kind of life. Do NOT u	usual occupation work done during more retired.)		Own He			
BE COM	17. FATHER'S NAME (First, Middle, Last) Albert		SCHULTZ		18. MOTHER'S NA Isabe	ME (First, Middle, Meiden		EBRA	ND
10	190. INFORMANT'S NAME (Type/Print) Mr. James E. Baker					t, Frederic			nd 21701
	200. METHOD OF DISPOSITION 1.A. Paurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 200. PLACE AND DATE Of DISPOSITION (Name of Completing Specific Property of what placed in Cardens, June 28, 1995 Frederick, Maryland								
	21. SIGNATURE OF PUNERAL SERVICE LICE	That.	MOO255	Keeney 106 Ea	st Churc	sford P.A. ch St., Fre	ederic	k, M	
								interval Between Onset and Death	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								
AL A	Coronary Artery Disease Coronary Artery Disease □ PERFORMED? □ YES 2\\ X\ NO					CO OF	RE AUTOPSY FINDINGS ALLABLE PRIOR TO MIPLETION OF CAUSE DEATH? YES 2 NO		
CIAN:	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		F DEATH YE	TH (Check only one)	UNCERTAIN	10			
PHYSICIAN: MEDIC	3737	MOSPITAL: No inpatient 2 ER/Outp 28e. DATE OF INJURY (Month, Day, Year)	28b. TIM		IRY AT	8 Other (Specify) 28d. DESCRIBE HOW IN	NJURY OCCUI	RED	
≧	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, atc. (Spec	— At home, ferm, i		ES 2 NO	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			o Number,
COMPLETED		AN: To the best of my knowl On the basis of examination							od menner ee stated.
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	Im A-Vita	ulb m.	0.	29c. LICENSE NUN D 27544	IBER	29d. DATE S	SIGNED (Mo	onth, Day, Year)
É	Dr. John A. Vitar	cello MD 3	10 West	Ninth St	reet, F	rederick, 1	Maryla	and 2	1701
	JUN 2 6 1995	32. RESISTEME SIGN	TURE Randal	Ñ.					



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BALTIMORE, MARYLAND 21215-0020	S
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P.O. BOX 6	ith certificate be ex
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VISION OF VITAL RECORDS, P.O. BOX	ING PHYSICIAN: The law requires that the death certificate be
DIVISION OF VITAL RECORDS, P.O. BOX 68760	w requires that the death certificate be

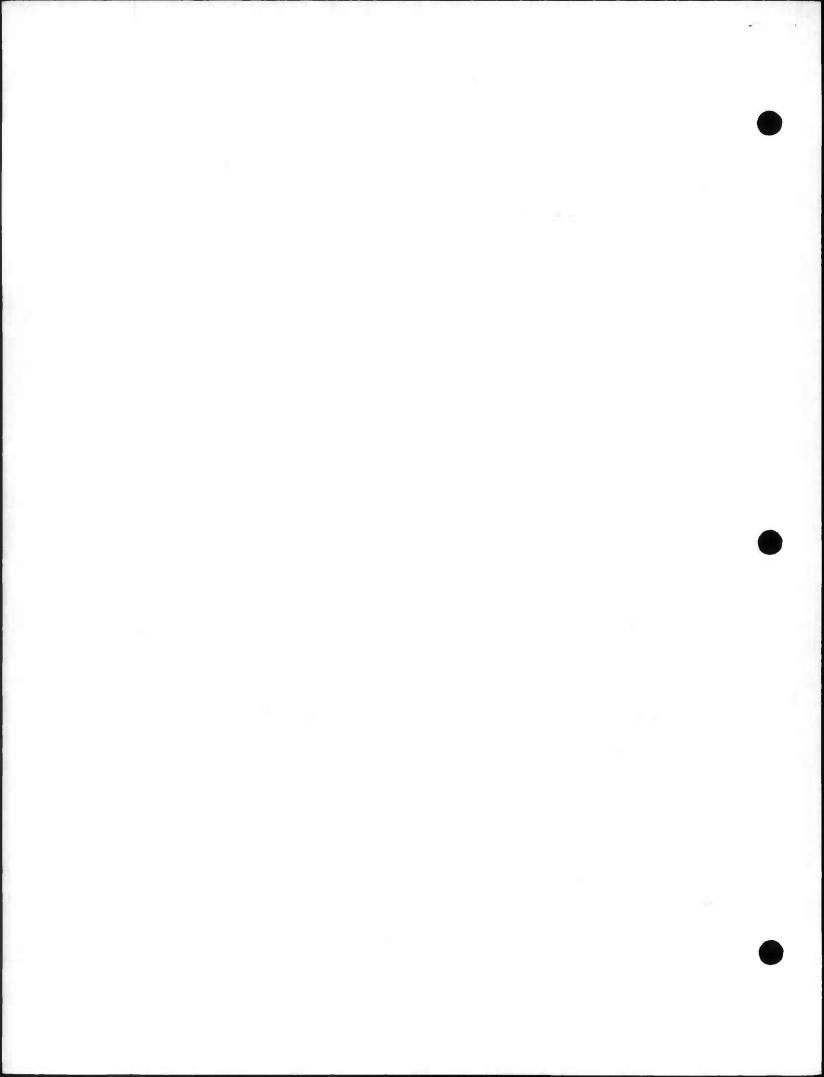
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALT	TH AND MENTAL HYGIENE
CERTIFICATE OF DE	ATH REG. NO.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
	1. DECEOENT'S NAME (First, Middle, Last					2. DATE OF DEATH		3. TIME OF DEATH
	Lo	ouisa Catheri	ne Brande	nburg			1995	6:10 A. M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs, last birthday)	IF UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year)	8. BI	RTHPLACE (State or Foreign ountry)
	219-46-1064		88 YRS.	DAYS .	HOURS MIN.			Md.
~	9a. FACILITY NAME (If not institution, give		1		R LOCATION OF DEA	ТН	Oc. COUNTY O	
0	Frederick Memorial Hospital			Fre	derick		Fred	erick
DIRECTOR				IC. CITY, TOWN OR LOCATION				10d. INSIDE CITY
	Md.	Frederick		Jeff	erson			1 YES ZYNO
\¥ ₩	10e. STREET AND NUMBER			101.	ZIP CODE		10g. CITIZEN C	F WHAT COUNTRY?
FUNERAL	6203B Mountair				21755		U.S.	
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 YES	2 XNO	If yes, spe	cify Cuban, Maxican,	C ORIGIN? (Specify Yes Puerto Rican, atc.)		ACE — American Indian, llack, Whita, atc.
B	3 ₩ Widowed 4 □ Divorced	IF YES, GIVE WAR OR	OATES	1 TYES	2X NO Specify:		s	White
	15. DECEDENT'S ED (Specify only highest grad	UCATION de completed)	18a. DECEDENT'S U	ISUAL OCCUPATION	N Lat working	16b. KIND OF BU		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ifte. Do NOT use	retired.)	-			
₽	8		<u>h</u>	omemaker			own ho	me
	17. FATHER'S NAME (First, Middle, Last) Charles Frankl	in Rusgard				E (First, Middle, Meiden len Carte		
B	19a. INFORMANT'S NAME (Type/Print)	III Dabbard	195 MAILING	INDRESS /Street or		rute Number, City or Tow		
임						d., Middl		
	20a. METHOD OF DISPOSITION 1 1 Buriel 2 Cremetion 3 Re		D. PLACE ANODATE OF	F DISPOSITION (Nan		-	CATION City o	
1 1	4 🗋 Donation 5 🗆 Other (Specify)	G	rossnickl	er place) e Cemete	ry	6/23 Mye	rsville	. Md.
1 1	21. SIGNATURE OF FUNERAL SERVICES				O AOORESS OF FACI	pson Fune		
Ш	March 3	hoppen		31 E.	Main St.	, Middlet	own, Md	. 21769
1	23. PARI & Enter the diseases, or ahock, or heart fallure	complications that cause. List only one cause on	ed the death. Do no	ot antar tha mod	la of dying, auch	aa cardiac or reapi	ratory arrest,	Approximate Interval Between
1 1	IMMEDIATE CAUSE (Final disease or condition		1					Onset and Death
	reaulting in death)	In oid Hemmorase			week			
_	Sequentially list conditions To Arteriosclevotic Vascular Disease							
CERTIFICATION	If any, leading to immediate							
S	cause. Enter UNDERLYING CAUSE (Disease or Injury	C						
間	that initiated eventa resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF)					
빙		d						
AL	PART II. Other aignificant condition	na contributing to dasth	but not reaulting in	the underlying	cause given in P	art I. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
EDIC						t 🗀 YES 2	XNO	COMPLETION OF CAUSE OF DEATH?
Σ						_	.	1 YES 2 NO
AN	DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL	CONTRIBUTE TO	CAUSE OF					
PHYSICIAN:	EXAMINER?	HOSPITAL:		OTHER:	ACE OF DEATH (Chec			
HX	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME	OF 28c, INJU	5 Residence 8	Other (Specily) 28d. DE\$CRIBE HOW I	NJURY OCCURE)
ВУ Р	1 Naturel 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU		NK? ES 2 NO			
ED B	3 Suicide 8 Could not be	28a. PLACE OF INJUR building, atc. (Spi	RY At home, farm, at ecify)	reet, factory, offica		28f. LOCATION (Street a City or Town, State)		ral Route Number,
13	4 Homicide determined							
절		SICIAN: To the best of my know						
COMPL	2 MEDICAL EXAMIP	NER: On the basis of axeminati	on and/or investigation	, in my opinion, da	ath occured at the ti	me, data and placa, an	d due to the cau	se(a) and manner as stated.
H	296. SIGNATURE AND TITLE OF CERTIFI	ER /	1		29c. UCENSE NUMB	DER	29d. DATE SIGN	ED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF O	FATH (ITEM 27) (Time I	Print)	10000	7) /	6	22/95
	TENSON TENSON T	TOWN ELIEU CAUSE OF U	esseri (irisəl 27) (1ype, 1	int)			•	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG	MATURE CONSTRUCTION ROUGH					
	JUN 2 3 19	35 Ilin Dan	whor Korbett	1				
	A = 1.							OHAH 40 Day 4700



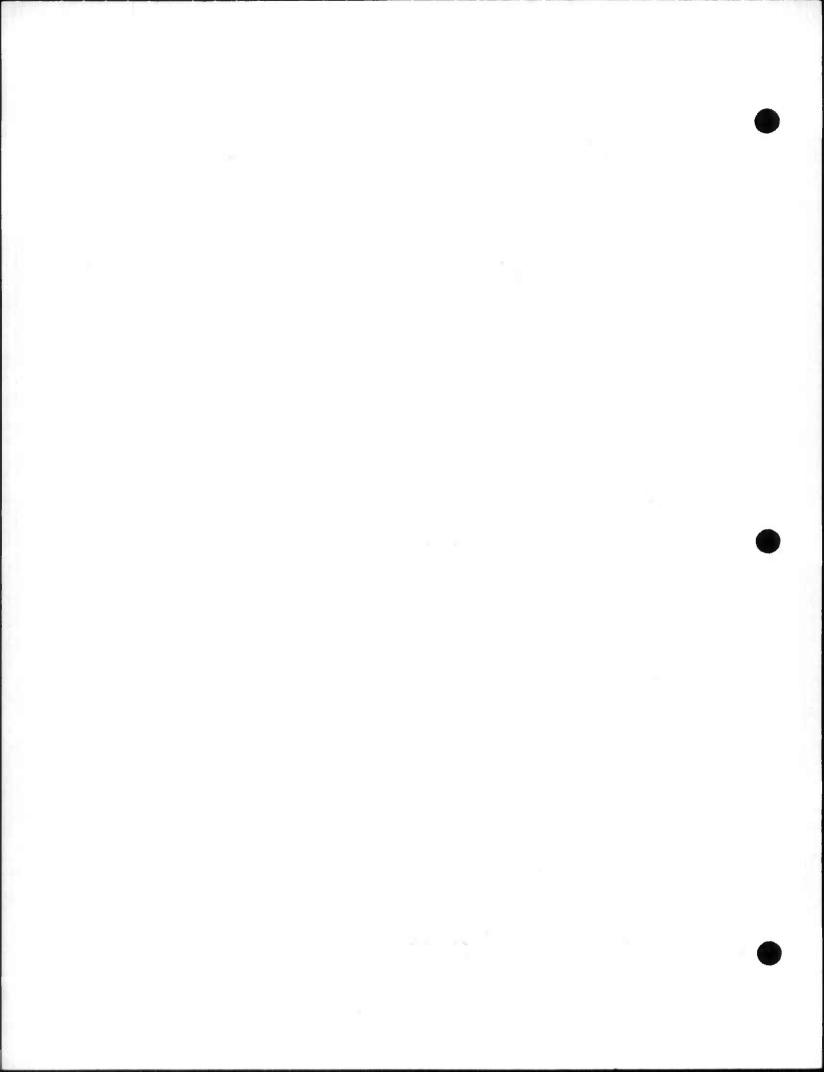
DIVISION OF VITAL RECORDS, P.O. BOX 68769

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Lest) EUGENE BOYD			R			7 1995	3. TIME OF DEATH 5:47 PM		
FUNERAL DIRECTOR	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest 121–14–4095 1 1 1 2 1 F 79			$\begin{array}{c ccccccccccccccccccccccccccccccccccc$			a punt	HPLACE (State or Foreign		
	9a. FACILITY NAME (If not institution, give street and number)						9c. COUNTY OF I			
	PENINSULA REGIONA		SALISBURY WICOMI							
	MD . WICOMICO			10c. CITY, TOWN OR LOCATION SALISBURY				10d. INSIDE CITY LIMITS? 1. YES 2 \(\square\) NO		
	300 lemmon hill la.			106	21801		10g. CITIZEN OF			
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. AI FDRCES? 1 YES 2 WIF YES, GIVE WAR OR DATES			13. WAS DEC	E — American Indian, k, Whita, atc.					
0	15. DECEDENT'S ED	16a. DECEDENT'S	ECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY							
PLET	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4 or 5+)			the kind of work done during most of working . Do NOT use retired.)				BING & HEATING		
COMPL	17. FATHER'S NAME (First, Middle, Last)				ME (First, Middle, Maiden :		MBATING			
BE	EUGENE B. 19a. INFORMANT'S NAME (Type/Print)	BISHOP	Tank Manusia	1000500 (0)		LSIE SISS				
10	EVELYN B.	BISHOP						MD. 21801		
	20a. METHOD OF DISPOSITION 1 Burlel 2 Tormation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) CAMBRIDGE CREMATORY 6-20 CAMBRIDGE, MD.									
	21. SIGNATURE OF FUNDIAL SERVICIPLICENSES 22. NAME AND ADDRESS OF FACILITY									
	BOUNDS FUNERAL HOME, SALISBUR									
0	Approximate interval Between Onset and Dear diseases or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or reapiratory arreet, interval Between Onset and Dear disease or condition and the control of the contro									
z	DUE TO (DR AS A CONSEQUENCE DF);									
SATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A EDNSEQUENCE OF): C. DUE TO (OR AS A EDNSEQUENCE OF): d.									
CERTIFICATION										
AL C	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS PRICE TO AMAILANCE PRICE TO AMAILANCE PRICE TO									
PHYSICIAN: MEDIC	17 Mg 1 mileton Demand 1 VES 2 NO DE									
AN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
SICI	25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 YES 2 NO 28. PLACE OF DEATH (Check only one) OTHER: 1 Norsing Home 5 Residence 6 Other (Specify)									
	27. MANNER DF DEATH 1 Netural 5 Pending	28e. OATE OF INJURY (Month, Day, Year)	OF 28c. INJU	F 28c. INJURY AT 28d. OEŞCRIBE HOW INJURY OCCUREO WORK?						
ED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE DF INJURY building, etc. (Spec	— At home, farm, st	1 TES 2 NO				Route Number,		
LETI										
COMPLETED	298. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: Dn the basic of my knowledge, dasth occurred at the filme, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: Dn the basic of examination and/or investigation, in my opinion, death occurred at the filme, data and place, and due to the cause(a) and menner as stated.									
BE	296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Morrith, Dey, Year) D 4 9 6 9									
10	30. NAME AND RODRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) 30. NAME AND RODRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) 30. NAME AND RODRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) 30. NAME AND RODRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) 30. NAME AND RODRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) 31. NAME AND RODRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) 32. NAME AND RODRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) 33. NAME AND RODRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) 34. NAME AND RODRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) 35. NAME AND RODRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) 36. NAME AND RODRESS OF GEATH (ITEM 27) (Type, Print) 37. NAME AND RODRESS OF GEATH (ITEM 27) (Type, Print) 38. NAME AND RODRESS OF GEATH (ITEM 27) (Type, Print) 39. NAME AND RODRESS OF GEATH (ITEM 27) (Type, Print) 39. NAME AND RODRESS OF GEATH (ITEM 27) (Type, Print) 39. NAME AND RODRESS OF GEATH (ITEM 27) (Type, Print) 39. NAME AND RODRESS OF GEATH (ITEM 27) (Type, Print) 39. NAME AND RODRESS OF GEATH (ITEM 27) (Type, Print) 39. NAME AND RODRESS OF GEATH (ITEM 27) (Type, Print)									
	31. DATE FILEO (Month, Day, Year) 32. PEGISTRAR'S SIGNATURE JUN 201995 Filia Davelin Randell									
1	2011 20 1000									



REG. NO.

BALTIMORE, MARYLAND 21215-0020

FOR

REGISTRAR

BOX 68760 P.0 DIVISION OF VITAL RECORDS,

30. NAME AND ADD

homa

31. DATE FILED (Month, Day, Year)

JUN 20

Divi

1995

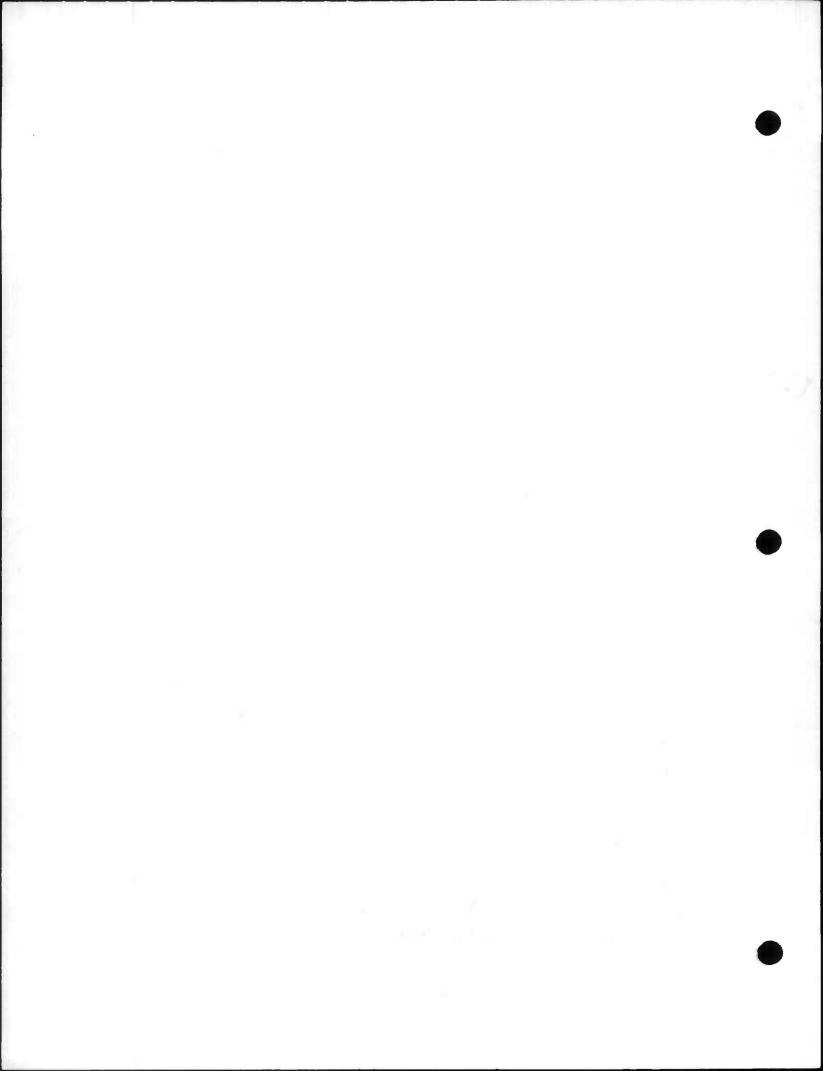
32. REGISTRAR'S SIGNATURE

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH CLIFFORD SCOTT JUNE 17 1995 BEALL 1:16 p A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign HOURS 220-28-2050 1 X M 2 F 62 YRS March 24, 1933 Maryland Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR EASTON MEMORIAL HOSPITAL Talbot Easton RESIDENCE OF DECEDENT 10b. COUNT 10c CITY TOWN OR LOCATION 10d. INSIDE CITY Maryland Caroline Federalsburg permit. 1 YES 2 X NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 23975 Richardson Rd. 21632 USA use as the burial-transit feath. Page 6 may be retained by the hospital or attending physician. funeral director, page 5 should be detached for use as the burial-tran 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ∑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-14. RACE - American Indian, Black, White, atc. 1 Never Married 2 K Married If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES ZONO BY Specify 3 Widowed 4 Divorced Specify: Navy White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 8 Mechanic Factory Equipment once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Malden Surname Ferris Benjamin 70 Winfield Scott Beall Grace BE notified 18s. INFORMANT'S NAME (Top-Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 23975 Richardson Rd., Federalsburg, MD 21632 Ruth C. Beall hours after death. Page 6 may be 9 20a. METHOD OF DISPOSITION
1 Depution 5 Definer Spe 20c. LOCATION - City or Town, State 20b PLACE AND DATE OF DISPOSITION (Name of must DATE alisbury Crematory 6/19 Salisbury, MD traumatic event, the medical examiner AL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home filled in by the fillen, or removal. 501 Snow Hill Rd., Salisbury, MD 21801 the diseases. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on settle Interval Between n and completely filled in to burial, cremation, or MEDIATE CAUSE (Final Onset and Death disease or condition_ resulting in death) DOE TO (OR AS A CONSEQUE DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate attending physician prior cause. Enter UNDERLYING CAUSE (Disease or injury other signed by the attending phy Health and Mental Hygiene that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST Injury, or PART II. Other significant conditions contributing to death but not reaulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any 1 TES 2 NO 1 | YES 2 | NO peeu DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate h Hem HOSPITAL: OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 MODOA 4 Nursing Nome 5 Residence 8 Other (Specify) 6 the 27. MANNER OF DEATN 28a, DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED marked, this c 1 Matural 5 Pending 1 YES 2 NO BY After 1 Investigation 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 28 is 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ED 8 Could not be DIRECTOR: A 4 Homicide determined TO THE HOSPITAL OR ATTO THE FUNERAL DIRECT DE filed within 72 hours a IMPORTANT: If Itom 2 COMPLET 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the besia of axamination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFI 29c. LICENSE NUMBER 29d. DATE SIGNED (Mgnth, Day, Year) BE 2 COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Pyrit)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

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		should be detached filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pay burial, cremation, or removal.
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BALTIMORE, MARYLAND 21215-0020	90	age
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30X 68760	te be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	sician and completely filled in by the funeral prior to burial, cremation, or removal.
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		1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							(
			1. DECEDENT'S NAME (First, Middle, Last)		10	1 1	2	DATE OF DEATH	V VEAD	3. TIME OF OEATY		
			4. SOCIAL SECURITY NUMBER		124	Y DOUY	Ve	ine 20,	1995	850 A "		
	l/11 ≌		577-44-0783	1 □ M 2XXF 62	in yrs. last birthday YRS.	MONTHS DAYS	HOURS MIN.	Month, Day, Year, June 21,	1932 VIF	THPLACE (State or Foreign ntry) RGINIA		
	3 should	œ	9a. FACILITY NAME (If not institution, give stre				OR LOCATION OF DEATH	1	9c. COUNTY OF			
	1, Z.	OTC	2506 St. Clair Drive Temkple Hills Prince Georges									
ć	Sec.	DIRECTOR	Maryland Prince	100, 011, 1				TOWN OR LOCATION LE Hills				
	Dermi		10e. STREET AND NUMBER			IOF, ZIP CODE 10g. CITI			1 XYES 2 NO			
ú.	an.	FUNERAL	2506 St. Clair Dr				20748		United	states		
21215-0020 al or attending physician.	ure buriat-transit permit. Pages	E I	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. WAS OECEDENT EVER IN FORCES? 1 1 YES IF YES, GIVE WAR OR DA	2 X NO	If yes, sp	CENDENT OF HISPANIC (Decity Cuban, Maxican, P 2 NO Specify:	ORIGIN? (Specify Year uarto Rican, etc.)	Bla Spe	CE — American Indian, ck, White, etc. ccty:		
215 atten	by the hospital or attendi be detached for use as 1 at once.		15. DECEDENT'S EDUCA (Specify only highest grade of	16a. DECEDENT'	EEDENT'S USUAL OCCUPATION e kind of work done during most of working							
14 m 1		J.	Elementary/Secondary (0-12)	College (1-4 or 5+)	Illia Do MOT use retired 1			Hospi	to1			
ANG e hos		BE COMPLETED	17. FATHER'S NAME (First, Middle, Last)						Hospital Widdle Maiden Surgement			
YL,	3 78		Tobey Bates				18. MOTHER'S NAME (First, Middle, Meiden Surmarne) Lottie Cousin					
MARYLAND retained by the hospit	notitied	2	19a. INFORMANT'S NAME (Type/Print)				and Number or Rural Rout			207/0		
60 6	2		Lawrence A. Barbou				r Drive,			20748		
BALTIMORE, or death. Page 6 may be	mus		20s, METHOD OF DISPOSITION 1\(\sum_{\text{N}} \) \(\text{Buriel} \) 2 \(\sum_{\text{Cremetion}} \) 3 \(\text{Remon} \) Remond 4 \(\sum_{\text{Donation}} \) 0 Other (Specify)	ral from State 20b.		of disposition (Ne other place) IEMORIAL			DOVER, N	IARYLAND		
LTIN Ith. Pag	examiner examiner		21. SIGNATURE OF FUNERAL SERVICE LICE	NSPE	260.54	A T 1237 A	NDER S. PO	OPE FUNER	AL HOMES	3		
- 23 -	2 7 60		Mey S	TURED.	M859	5538	Marlboro 1	Pike, For	estville			
ithirred hours	cremation. or		23. PART I. Enter the diseases, or co shock, or heart failure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death)	ist only one cause on ea	ich line.		iske all			Approximate Interval Between Onset and Death		
DX 68 be execu	v requires that the death certificate be executed been signed by the attending physician and it. of Health and Mental Hygiene prior to but is shows any Injury, or other traumatic	CERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST b. OUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
S, F			PADE-II Wher significant conditions	contribution to death by								
C = 3		PHYSICIAN: MEDICAL	PERFORMED? AMAILABLE PRIOR TI COMPLETION OF CA OF DEATH?							b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
> ~		Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
The Table	The ate bare		25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:									
F VIT	e &	14S	1 VES 2 NO	28a, OATE OF INJURY	tient 3 DOA	4 - Nursing Hom	e 5 E Rasidenca 6		well a series			
0 1	The Par	BY P	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)		JURY WO	PK?	d. DESCRIBE HOW IN	JURY OCCURED			
DIVISION OF VI'S OR ATTENDING PHYSICIAN:	after d	_	3 Suicide 6 Could not be detarmined	26a. PLACE OF INJURY building, etc. (Specif	— At home, farm,	street, factory, office	28	I. LOCATION (Street an City or Town, State)	nd Number or Rural	Route Number,		
DIN HOSPITAL OR	2 =	COMPLETED		AN: To the best of my knowle On the basis of examination						(a) and manner as stated		
THE HOS		BEC	296. SIGNATURE AND TITLE OF CENTISEST				29c LICENSE NUMBER			D (Month, Day, Year)		
2	INPOR	0 6	SUGUES OF BENSON WHO	CONFLETED CAUSE OF DEA	TH OTEM ST. /F-	Print)	421230	7	Kine;	20,1995		
(10	3)	1	31. DATE FILED (Month, Day, Year)	que Mo.	5009	Rayhu	sock Cy	Samy	s,Mo	20748		
			TIN 23 1995	Alia Davidson K	arbeth			V //				

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68769

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO

	REGISTRAR		CERTIF	ICALE	P DEATH	REG. NO),			
		BIMBO				2. DATE OF DEATH MONTH JUNE 5 1995 9:18 A				
R	4. SOCIAL SECURITY NUMBER 337–56–7054	1 □ M 2 X F 75	In yrs. last birthday) YRS.	IF UNDER 1 YE		7. DATE OF BIRTH (Month, Day, Year)	20 _ °	BIRTHPLACE (State or Foreign Country)		
	9e. FACILITY NAME (If not institution, give sti GREATER LAUREL HO		9b. CITY, TOWN OR LOCATION OF DEATH LAUREL			PRINCE GEORGES				
15	RESIDENCE OF DECEDENT						PRINC	E GEORGES		
DIRECTOR	10a. STATE 10b. COUNTY	_		Y, TOWN OR L				10d. INSIDE CITY LIMITS?		
	Florida Broward Hollywood									
1AL	10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUI									
FUNERAL	303 North Rainbow Drive 33021 U.S.A.									
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	S 2 NO If ye		DECENDENT OF HISPANIC ORIGIN? (Specify Yes, specify Cuban, Maxican, Puetro Rican, etc.)		a or No— 14.	RACE — American Indian, Black, White, atc.		
B	3 XWidowed 4 Divorced	ATES **	1 🗆	YES 2 XNO Speci	ffy:		Specify: nite			
유	15. DECEDENT'S EDUC (Specify only highest grade of	ATION	18a. DECEDENT'S	USUAL OCCUP	ATION	16b. KIND OF BU				
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	IIIe. Do NOT u	se retired.)	most of working					
COMPLETED	Unknown		Homen	naker		Own Home				
	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S N. Rosie	Sumame)				
BE	George Davis 19a. INFORMANT'S NAME (Type/Print)		19h MAII ING	ADDESC (Se		Route Number, City or Tow	- Out 7/2 Out			
5	Peter S. Bimbo					ne, #33, L				
	20a. METHOD OF DISPOSITION 1 Buriat 2 Cremation 3 Rema		PLACE AND DATE	OF DISPOSITION			CATION — City			
	4 Donation 5 Other (Specify).		etery, crematory or o	en of H	eaven	6/23/95	Worth Tax	derdale, FL		
	22. NAME AND ADDRESS OF FACILITY Rendon/Hale Funeral Home									
	Muhane	Send	1_	9013	Annapoli	s Road, La	nham. M	4D 20706		
	23. PARTI. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, abook, or heart fellure. List only one cause on each line. Approximate interval Batween Onset and Death disease or condition resulting in death) Due to (or as a consequence of the consequence of the cause)									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST b. REAL DISEASE OF THE CONSTRUCT OF T									
	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? PART AMAILABLE PRIOR TO									
EDICAL	DIA TULE WIO aUTOFU. CHRONIC ONGTRUCTIVE 10 YES 2 DAYS									
E I	PULMONORY DEFENCE									
Ä	DID TOBACCO USÉ CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 UNO 1 Constant 2 ER/Outpetient 3 DOA A Number Many 6 Periodece 9 Constant 1									
H	27. MANNER OF DEATH	1 ☐ Inpatient 2 ☐ ER/Outp	atlant 3 DOA	- T-	INJURY AT		N HIDY OCCUPE	-		
	1 Naturel 5 Pending		URY	WORK?	28d. OEŞCRIBE HOW INJURY OCCUREO					
р Ву	2 Accident Investigation 3 Suicide 8 Could not be	— At home, term,	At home, term, street, factory, office		281. LOCATION (Street and Number or Rural Route N					
1	4 Homicide determined building, atc. (Specify) City or Town, State)									
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as attend. 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as attend.									
	29b. SIGNATURE AND THE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE (Month, Day, Year)									
TO BE	25 c/m MD 0 38958 > 6/6/95									
	OR NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) OHLTEET SINGH SIDMU 1413 HANNHOLIS ROLD #106, OBENTON MID 21/13									
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	1413 NT/URE	HNNIF	MULIS K	9 HD # 106	OBEN	110N MUZIII3		
	JUN 21 1995 July	32. REGISTRAR'S SIGNAL	il,							

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and heart heart heart. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Heatth and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

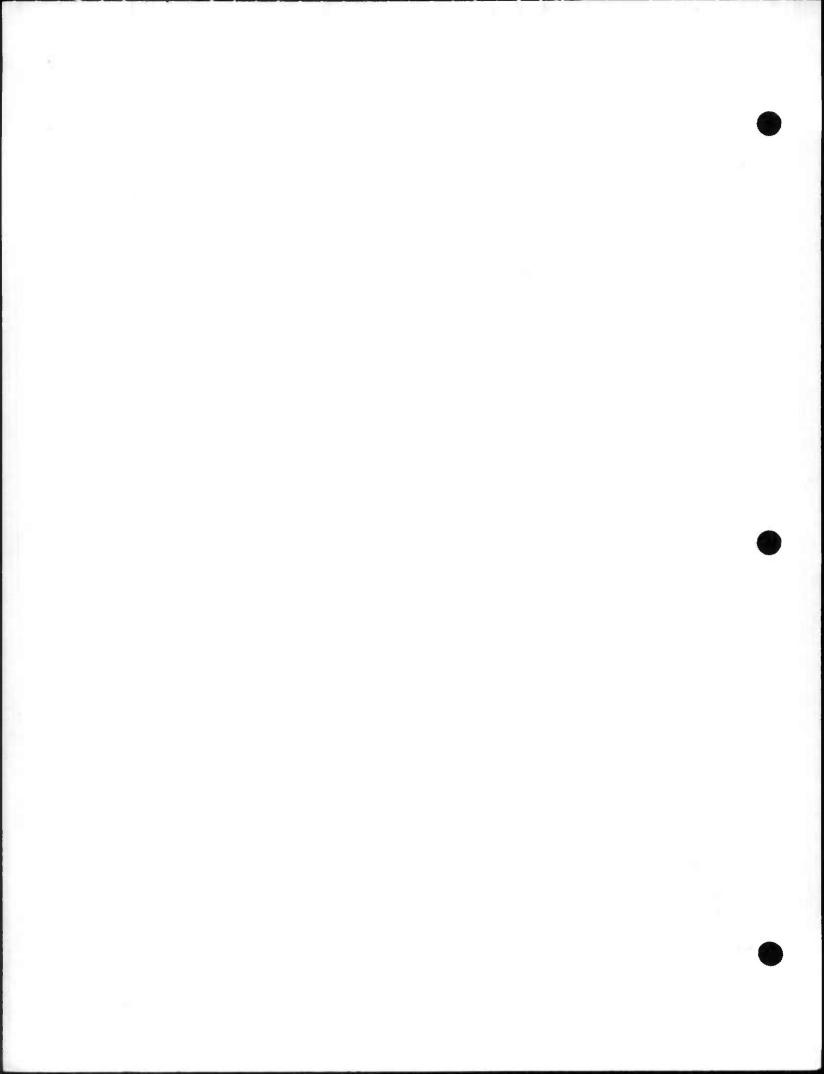
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68769

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	REGISTRAR		CE	RTIF	ICATE C	F DEATH		REG. NO).		
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE (OF OEATH			3. TIME OF OEATH
	DOROTHY	E. BARWI	CK				Time	20,	1995	YEAR	12:25 A. M
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last	t birthday)	IF UNDER 1 YE	R IF UNDER 24 HRS.			1993		IPLACE (State or Foreign
	579-03-5987	1 □ M 2 🔯 F		YRS.	MONTHS DAY		(Month,	Day, Year)		Counti	(y)
	9a. FACILITY NAME (If not institution, give s	Λ	77	17.0.				6, 1			hington, DC
\ m	98. FACILITY NAME (If not institution, give a	street and number)		- 1	9b. CITY, TOV	N OR LOCATION OF	DEATH		9c. COU	NTY OF D	EATH
DIRECTOR	9015 Columbine L	ane			Upper	Marlboro			Pri	nce (George's
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT										
					r, TOWN OR LO						10d. INSIDE CITY LIMITS?
		e George's	3	Upp	per Mai	1boro					1 TES 2 NO
A	10e. STREET AND NUMBER					10f. ZIP CODE			10g. CIT	IZEN OF Y	WHAT COUNTRY?
FUNERAL	9015 Columbine L	ane				20772			Uni	ted 9	States
3	11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. ARI	MED	13, WAS	DECENDENT OF HISP	ANIC ORIGIN?	(Specify Ye			E — American Indian,
	1 Never Married 2 Married	FORCES? 1 I	YES 2 N	10	If yes	specify Cuben, Maxi	can, Puarlo Ri	can, etc.)		Biaci	k, White, etc.
B	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE WAR	OR DATES		10	YES 2X NO Spe	city:			Speci	White
	15. DECEDENT'S EDU	CATION	16a, DE	CEDENT'S	USUAL OCCUP	ATION	1466	KIND OF BU	CINECCINI	DUCTON	MILLE
COMPLETED	(Specify only highest grade	completed)	(G/	ve kind of w	vork done durine	most of working	100,	KIND OF BU	SINE 33/INI	DUSTRI	
ا يّ ا	Elementary/Secondary (0-12)	College (1-4 or 5+)		omema				wned	II		
2			n.	omema	iker						
8	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S			Sumame)		
B	James Edwin Magr	uger				Floren	ce Wal	ton			
2	19a. INFORMANT'S NAME (Type/Print)		196	. MAILING	ADDRESS (Stre	et and Number or Rure	I Route Numbe	r, City or Tow	n, Stete, Zip	Code)	
F	Barbara Brown		90	015 (Columbi	ne Lane,	Upper	Mar1	boro	. MD	20772
	20a. METHOD OF DISPOSITION		20b, PLACE A	ND OATE C	F OISPOSITION	(Name of	DATE	20c 10	CATION -	Cify or To	wn State
	1 Buriel 2 X Cremation 3 Rem 4 Donation 5 Other (Specify)	ovat from State	cemetery, crer	natory or of	her place)	ematory 6	/21/05	Day	n +110	o, o	Money 1 om J
	21. SIGNATURE OF FAMERAL SERVICE LA	Source A /	TOLL	LINC		AND ADDRESS OF		DIE	HLWO	οα, .	Maryland
	. 4 . 0	The a	/		Fort	Lincoln	Funer	al Ho	me.	Inc.	
	MARK	LUGA	MI								MD 20722
	23. PART. Enter the diseases, or	complications that co	aused the de	ath. Do n							Approximata
	shock, or heart fellure.	List only one cause	on each line.					ac or reap	natory an	out,	Interval Between
	IMMEDIATE CAUSE (Final disease or condition	-14			_	_					Onset end Death
	resulting in death)	Metastat				he Pancr	eas				4 Months
		DUE TO (OF	R AS A CONSEC	UENCE OF):			_			
z	of the same of the	b									
CERTIFICATION	Sequantielly list conditions, if any, laeding to immediate	DUE TO (OF	AS A CONSEO	UENCE OF):						
8	cause. Enter UNDERLYING CAUSE (Disease or Injury	С,									
틸	that initiated events	DUE TO (OF	AS A CONSEQ	UENCE OF):						
토	resulting in deeth) LAST	d.									
岁											
A I	PART II. Other algnificant condition	a contributing to da	ath but not re	esulting i	n tha underly	Ing ceuse given i	n Part I.	24a, WAS AN PERFOR	AUTOPSY	246.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
EDICAL								1 TES 2			COMPLETION OF CAUSE
							_		22 110		OF DEATH?
Σ	DID TOBACCO USE CONT	DIRLITE TO CALIS	SE OF DEAT	TLL VE	C III NO	ET LINICEDTA	- I				1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	KIBUIL IO CAUS			H (Check only o						
ᅙ	EXAMINER?	HOSPITAL:	20. PLAC	T	OTHER:						
\Z	1 TYES 2 X NO	1 - Inpetient 2 - El	R/Outpatient 3	□ DOA	4 - Nursing I	lome 5 Residence	8 🗆 Other	(Specify)			
품	27. MANNER OF DEATH	26e. DATE OF IN. (Month, Day,	JURY Year	28b. TIME	OF 28c.	INJURY AT WORK?	28d. DESC	RIBE HOW I	NJURY OC	CURED	
ВУ	1 Netural 5 Pending 2 Accident Investigation	(,,			4.4	YES 2 NO					
	3 Suicide 8 Could not be	28s. PLACE OF IN	NJURY — At hor	ne, ferm, a	treet, factory, o	ffica	28f, LOCA	TION (Street	and Number	or Rumi R	Route Number,
ш	4 Homicide detarmined	building, atc.	(Specify)				City of	Town, State)			Training,
	29a. CERTIFIER										
필	(Check only 1 X CERTIFYING PHYS)	CIAN: To the best of my									
COMPLETED	one) 2 MEDICAL EXAMINE	R: On the basis of axam	ination and/or in	nventigation	n, in my opinio	n, death occured at th	e time, data a	nd place, an	d due to th	ne cause(s) and manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIE	R				29c. LICENSE N	JMBER		29d. OAT	E SIGNED	(Month, Day, Year)
BE	May C. C.	Jan. gr	-			D39550					20, 1995
2	30. NAME AND ADDRESS OF PERSON WH	/ //	OF DEATH (ITEM	27) (Xme	Print)	237330			- 50	ALIG Z	.0, 1777
	George C. Hajjar						.am 31	0 24 7	1 ^	0777	
H				ror	nes pl	va., Lani	iam, M	агута:	nd 2	20706)
	JUN 21 1995 Au	32. REGISTRAR'S									
10	LITTER OF THE SALE	MA WELLOCK	Adall								



6:45PM 8. BIRTHPLACE (State or Foreign Rock Hill, SC

> Approximate Interval Between Onset and Death week

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

REG. NO.

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

31, DATE FILED (Month, Day, Year)

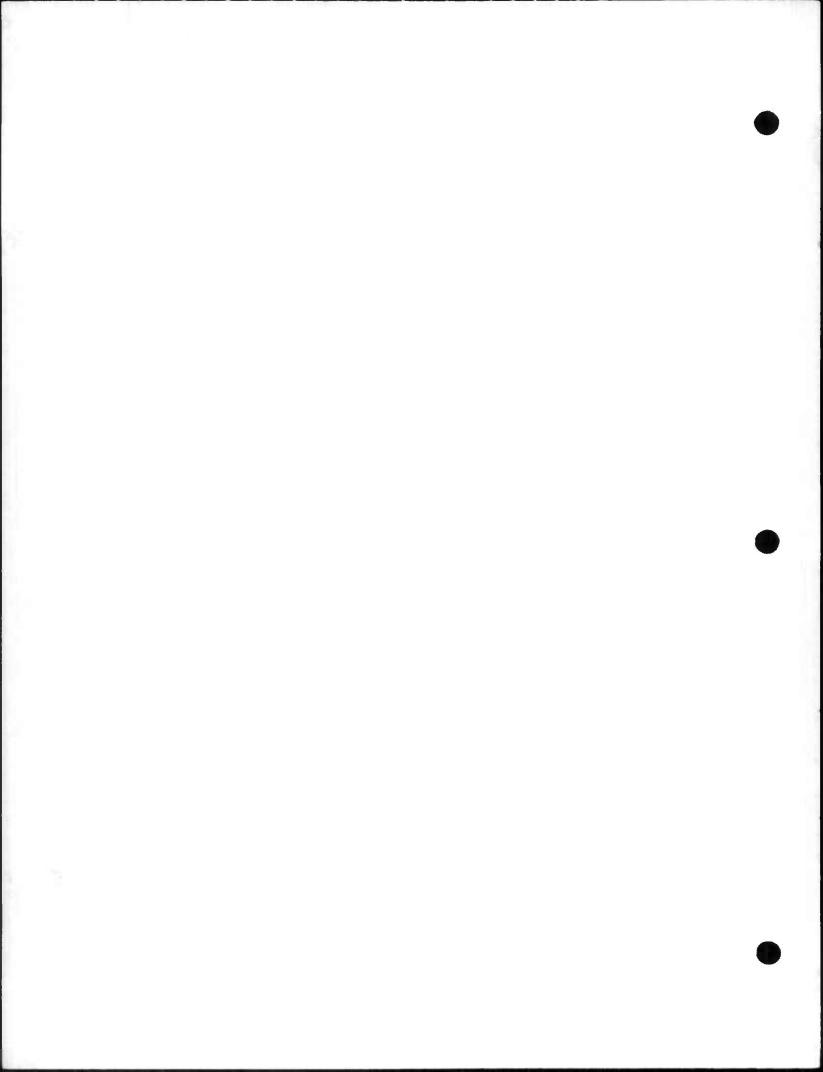
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		1. DECEDENT'S NAME (First, Middle, La	nt)						2. DATE OF DEATH MONTH	DAY	YEAR	3. TIME OF DEATH
		DORIS E.	B	ARBER					JUNE 16			6:45PM
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In y	rs. last birthday)	IF UNDER 1		IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTH Countr	IPLACE (State or Foreign
		240-52-5988	1 M 2 X F	6.	5 YAS.	MONTHS	DAYS	HOURS MIN.	5/31/30		Roc	k Hill, So
Should		90. FACILITY NAME (If not institution, give					TOWN O	R LOCATION OF		9c. COU	ITY OF D	EATH
, 60	стов	PRINCE GEORGE'S	COUNTY	MEDICA	AL CENT	ER		CHE	VERLY		PG	,
-	ᇤ	RESIDENCE OF DECEDENT 10e. STATE 10b. COU	ITV		40.00	Y, TOWN OR		and the second				
permit. Pages	DIR		PG .			LANDO						10d. INSIDE CITY LIMITS? 1 XYES 2 NO
	FUNERAL	10e. STREET AND NUMBER					tot,	ZIP CODE		10g. CITI	ZEN OF V	VHAT COUNTRY?
020 physician. burial-transit	5	1202 Capitol	/iew Drive	!				20785			USA	
20 ysicia rial-tr		11. MARITAL STATUS	12. WAS DECEDED			13. W	AS DECI	ENOENT OF HISP	ANIC ORIGIN? (Specify Yours, Puerto Rican, etc.)	e or No—	14. RACE	- American Indien, c. White, etc.
215-0020 attending physician. se as the burial-trar	ВУ	1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE					2 NO Spec				ack
	ED	15. DECEDENT'S E (Specify only highest gri		16	Sa. DECEDENT'S (Give kind of v	USUAL OCC	CUPATIO	ON st of working	16b. KIND OF BI	JSINESS/IND	USTRY	
	LET	Elementary/Secondary (0-12)	College (1-4 or 5	+)	life. Do NOT us	e retired.)			Post	auran	+	
MARYLAND 2 retained by the hospital 5 should be detached for notified at once.	COMPL	11 Yrs	None		Short	Order	- 00	JOK .	Kest	auran	L	
the horder	응	17. FATHER'S NAME (First, Middle, Last)						16. MOTHER'S N	ia Massey	Surneme)		
TARYL trained by should be stiffled at	BE	Page Bric	<u> </u>					-				
MAR retained 5 should notified	0	190. INFORMANT'S NAME (Type/Print) Charles Barber			19b. MAILING	ADDRESS (Street or	b, c, d, e	Poute Number, City or To	vn, State, Zip	Code)	
RE, F may be o x, page 5 st be n												
FORI e 6 may rector, p		20a, METHOD OF DISPOSITION 1X Burlel 2 Cremation 3 Re	moval from State		ACE AND DATE OF					Carlon - C		
BALTIMOR after death. Page 6 ma by the funeral director, promoval.	0.00	4 Donation 6 Other (Specify)	LICENSEE	- 110								
ALTIN death. Pag e funeral dir f. examiner		· Clus	. ((IN		AME AIV		THYT. Rhin			
BALT after death. by the funera moval.		- Juan	Um	m	YU.)30 12th St			.0017
2 6 5		23. PART I. Enjer the diseases, of ahock, or heart fellur	r complications the	t ceuaed th	ne death. Do n	ot enter th	he mod	de of dying, su	ch ea cerdlec or reas	iratory arr	eat,	Approximate
y filled is stion, or the me		IMMEDIATE CAUSE (Finel	^	4			-1	1.				Onset and De
mati		disease or condition reaulting in death)			og en i		Sh	OCK				Tweek
68760 ecuted withing and completely burial, cremat atlic event,	Ì		O DUE TO	(OR AS A CO	DISEQUENCE OF	7: /	1	0 1	0 - 0 4	D	. 4.4	30
and parit	NO.	Sequentially list conditions,	a Jeven	ay	newsc	Keu/	10	Caral	waxefol	DISE	We	- Sycure
	CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING) (C. /	OH AS A CO	ONSEQUENCE OF	ell	, 4	11				> 104eas
W 2 5 2 P	윤	CAUSE (Disease or Injury	c. DIE TO	(OR AS A CO	ONSEQUENCE OF		170					7 10 4 6 4
P.O.	Ē	that initieted events resulting in death) LAST	552 10	(011 A3 A 00	NASCOOENCE OF	7-						
	핑		d									-
F = 20 = 1	A	PART II. Other algnificent conditi		deeth but i	not resulting i	n the unde	erlying	ceuse given in		N AUTOPSY	24b.	WERE AUTOPSY FINDING
amy ar ar	EDICAL		max to	11/14	, rei	phe	lak	usu	UN 1 YES			AVAILABLE PRIOR TO COMPLETION OF CAUSE
RECC requires been signe of Healti shows a	WE	Disease				/		,				OF DEATH?
C = 3 . 5		DID TOBACCO USE CON	TRIBUTE TO CA	USE OF I	DEATH YE	S N	0 1	UNCERTA	IN 🗆			N/A
VITAL IAN: The law Tificate has the State Dep or Item 23	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26.	PLACE OF OEAT		ly one)					
F VIT, SICIAN: The certificate in the State i, or item	, Si	1 YES 2 NO	1 Dinpatient 2	ER/Outpatie	nt 3 🗆 DOA	OTHER:	g Home	5 - Residence	8 Other (Specify)			
VISION OF VI ATTENDING PHYSICIAN: ECTOR: After this certificals after death with the St 128 Is marked, or it	H	27. MANNER OF DEATH	28e. OATE OF (Month, L		28b. TIMI	E OF 20	8c. INJU	JRY AT	28d. OESCRIBE HOW	INJURY OCC	URED	
NG PHYS fter this sath with	BY	1 Natural 5 Pending 2 Accident Investigation		_			1 🗌 Y					
SION TENDING TOR: After offer death Si is man		3 Suicide 6 Could not b	26e. PLACE C building,	F INJURY — atc. (Specify)	At home, term, a	treet, factor)	y, office		26f. LOCATION (Street City or Town, State	end Number	or Rural A	oute Number,
DIVISION OR ATTENDING P DIRECTOR: After the hours after death v		4 Homicide determined										
DIV L OR A L DIREC L DIREC L hours	COMPLETED	290. CERTIFIER 1 CERTIFYING PH	SICIAN: To the best of	my knowledg	e, death occurre	d at the limi	e, date e	end place, end du	e to the ceuse(e) end me	nner ee atatr	d.	-
SPITA VERA	O								e time, date end place, e			end menner se stated.
TO THE HOSPITAL (TO THE FUNERAL C Be filed within 72 h IMPORTANT: If it		296. SIGNATURE AND TITLE OF CERTU						29c. LICENSE NU				(Month, Day West
THE CANADA	BE	/mn/	/cellol	Mi				D-11	289	D 6	, 7,	7/05
E E D E	유	30. NAME AND ADDRESS OF PERSON	VHO COMPLETED CAU	SE OF DEATH	(ITEM 27) (Type.	Print)		- /0		arts of	1"	1/40
/		Steven M.	Vollake.	MD	25216	5491.	JUL	my CT.	K DRIVE	6	earl.	elf mix

32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



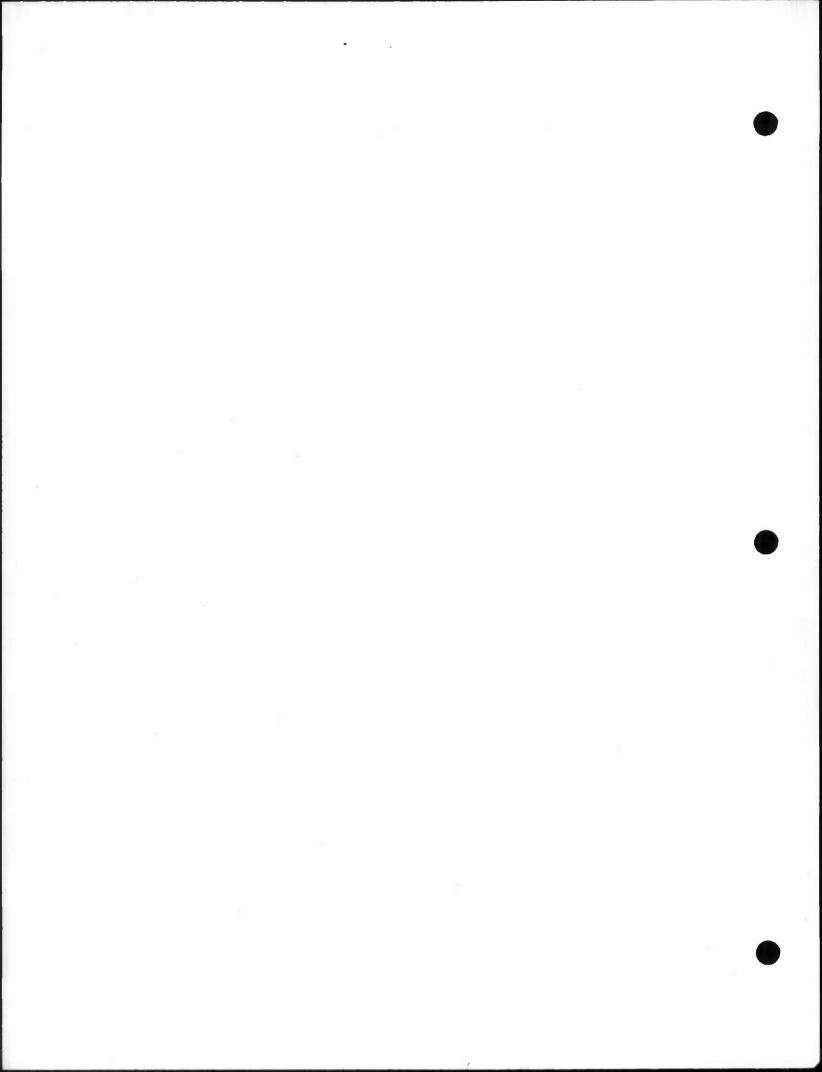
BALTIMORE, MARYLAND 21215-0020	d by the hospital or attending physici
TIMORE, MA	1. Page 6 may be retain
BALTIN	24 hours after death
68760	executed within
O.O. BOX	n certificate be
DIVISION OF VITAL RECORDS, P.O. BOX 6876	requires that the death
OF VITAL	HYSICIAN: The law
DIVISION	L OR ATTENDING P

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

R NTE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
BISTRAR	CERTIFICATE OF DEATH	REG. NO.

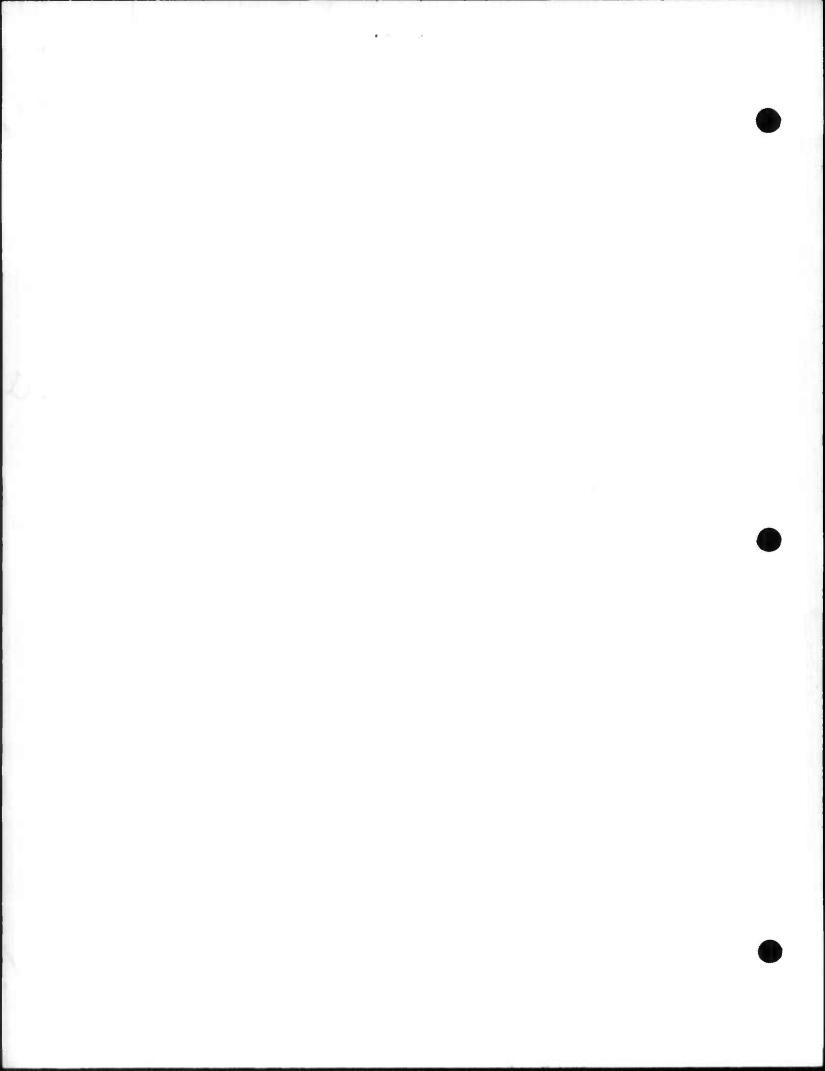
	1 - STATE REGISTRAR	STATE OF MARYL		ENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIEN						
	1. DECEDENT'S NAME (First, Middle, Last)	= -	- 4.50		2. DATE OF DEATH MONTH DA	3. TIME OF DEATH					
	JEAN K	1307 E			6 23	4//					
	578-22-3986	1 🗆 M 2 🔀 F	70 YRS. MO	UNDER 1 YEAR IF UNDER 24 HRS. ITHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Oct. 13,	a. BIRTHPLACE (State or Foreign Country) 1924 Washington DC					
DIRECTOR	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH ST. MARYS HOSPITHL LEONARD TOWN ST. MARYS RESIDENCE OF DECEDENT										
<u> </u>	10a. STATE 10b. COUNTY	Y	10c. CITY, TO	WN OR LOCATION		10d, INSIDE CITY					
E	Maryland St.	Mary's	Mec	hanicsville		LIMITS?					
\A	10s. STREET AND NUMBER			10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?					
FUNERAL	9 Ronald Drive			20	0659	USA					
B	11. MARITAL STATUS 1 Never Married 2 Married 2 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 DO	13. WAS DECENDENT OF HISP/ If yes, specify Cuban, Maxic 1 YES 2 NO Specify N	can, Puerto Rican, etc.)	or No- 14. RACE — American Indian, Black, Whita, atc. Specify: White					
	15. DECEDENT'S EDU- (Specify only highest grade	CATION completed)	16a. DECEDENT'S USU	AL OCCUPATION done during most of working	16b. KIND OF BUS	SINESS/INDUSTRY					
once.	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use ret	ired.)							
AP G	12		Credit Ad			Department Store					
5 8	17. FATHER'S NAME (First, Middle, Last)				AME (First, Middle, Maiden	Sumame)					
E B	Fingene Vernon Man	gum	19h MAILING ADE	DRESS (Street and Number or Rura	e Talbot	o State Tie Code)					
medical examiner must be notified at once. TO BE COM	Mary E. Dixon			Woodville Road							
The state of	20a. METHOD OF DISPOSITION	20b.	. PLACE AND DATE OF DI	SPOSITION (Name of	DATE 20c. LO	CATION — City or Town, Stata					
Ē	1 Donation 5 Other (Specify)		Resurrecti	on Cemetery	6-28 Cli	nton, MD					
nine.	21. SIGNATURE OF FUNERAL SERVICE LIG	ENSEE HOULE		22. NAME AND ADDRESS OF F	_						
odical exa	Mark G. Bro		00053	Huntt Funera		MD 20604-0156					
event, the	immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions,	b	CONSTRUCTION OF STREET	unt Trauma	woluding	head t interval Between Onset and Death chest					
traumatic CATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	DUE TO (OR AS A CONSEQUENCE OF):								
or other i	CAUSE (Disease or injury that initiated events	c. DUE TO (OR AS A	CONSEQUENCE OF):								
5 H	resulting in death) LAST	d									
L G	PART II. Other algnificent condition	a contributing to deeth b	ut not reaulting in th	e underiving ceuse given ir	Part I. 24a, WAS AN	AUTOPSY 24b. WERE AUTOPSY FINDINGS					
E S	EPFD, HSP	, Alvalfe			PERFOR	MED? AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?					
shows	DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	F DEATH YES I	□ NO □ UNCERTA	IN Π	1 TYES 2 NO					
Item 23 s	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)									
or Item	1 YES 2 NO	HOSPITAL: 1 Inpetiant 2 ER/Output		HER: Nursing Home 5 Residence	6 Other (Specify)						
	27. MANNER OF DEATH 1 Netural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJURY AT WORK?	28d. DESCRIBE HOW IP	NJURY OCCURED					
Is marked,	2 Accident Investigation	6/23/95	17591		MVA	28f. LOCATION (Street and Number or Rural Route Number,					
20 W	3 Suicide 6 Could not be 4 Homicide datarmined	28e. PLACE OF INJURY building, etc. (Speci	my)	, factory, offica	281. LOCATION (Street a City or Town, State) Golden Beau	Ind Number or Rural Route Number,					
를 로				the time, data and place, and du							
NA CO			and/or investigation, in	my opinion, death occured at th	e time, date and place, and	d due to the cause(s) and manner as stated.					
MPORTANT.	296. LICENSE NUMBER 296. LICENSE NUMBER 297. DATE SIGNED (Mopth, Day, Year)										
F	30. NAME AND ADDRESS OF PERSON WH		/								
	Dr. James C. Boyd			x 301, Leonar	dtown, MD 2	20650					
	31. DATE FILE UN. 2% 7 1995	JULA WHULL	arture or Rawfall								



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be field within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARY		TMENT OF H		MENTAL HYGIEI			
	1. DECEDENT'S NAME (First, Middle, Leal)					2. DATE OF DEATH		3. TIME OF DEATH	_
		Sue Be	rnardon			June 24	199	YEAR 10:28 P:	м
	The second of th		E (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8	. BIRTHPLACE (State or Foreign Country)	
		1 □ M 2 🙀 F	59 YRS.			Oct. 4,	1935	Washington D	C
œ	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH								
DT:	Physicians Memori	tal Hospita	ıl	La	aPlata		Ch	arles	
DIRECTOR	10a. STATE 10b. COUNTY			, TOWN OR LOCAT	TION			10d. INSIDE CITY	
		e George's	Bra	ndywine				1 YES 2 NO	
FUNERAL	10e. STREET AND NUMBER			101	ZIP CODE	-	10g. CITIZE	N OF WHAT COUNTRY?	
NE.	16501 River Airpor				20613			SA	
	1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 YE	S 2 NO	If yes, sp	ecify Cuban, Maxicai	IIC ORIGIN? (Specify Yen, Puarto Rican, etc.)	s or No 14	4. RACE — American Indian, Black, White, atc.	
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES	1 U YES	2 No Specify	r		Specify: White	
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade or	(TION ompleted)	16a. DECEDENT'S	USUAL OCCUPATIO	ON st of working	18b. KIND OF BU	ISINESS/INDUS		
	Elementary/Secondary (0-12)	College (1-4 or 5+)		rork done during mo e retired.)	or or working				
M	12 17. FATHER'S NAME (First, Middle, Last)		Law C	lerk		County		t Court	
		Totalia Cir				ME (First, Middle, Malder			
BE	George Celistine G	iateau, SI.		ADDRESS (Street a		eline A. D		adel	-
9	Michael R. Bernard	lon						, MD 20772	
	20a. METHOD OF DISPOSITION 1√2 Burlal 2 □ Cremation 3 □ Ramov	2	Ob. PLACE AND DATE O	F DISPOSITION (Na	me of			y or Town, State	
	4 Donation Other (Specify)		Resurrec			6-27 Cli	nton,	MD	
	21. SIGNATURE OF FUNERAL SERVICE DICE	NSEE			Funeral				
	Mark G. Broha			PO	box 156	Waldorf	MD 20	604-0156	
	23. PART i. Enter the diseases, or co shock, or heart failure. Li	mplications that caus at only one cause on	ed the deeth. Do n	ot enter the mo	de of dying, such	h as cerdiec or resp	iratory arres	t, Approximata interval Between	
	IMMEDIATE CAUSE (Final disease or condition	2		C 4	r D			Onset and Dec	
	resulting in death)	du UN	A CONSEQUENCE OF	CAN	LEK				
_		DUE TO (ON AS	A CONSEQUENCE OF):					
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE OF):					
CA	cause. Enter UNDERLYING CAUSE (Disease or injury								
불	thet initieted events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF):					
	d.								
AL	PART il. Other significant conditions	contributing to deeth	but not resulting i	the underlying	cause given in	Part I. 24a, WAS AP		24b. WERE AUTOPSY FINDING AMILABLE PRIOR TO	GS
8	DIABE	JES	ME	LLI	TYS	1 [] YES		COMPLETION OF CAUSE DF DEATH?	:
ME							/-	1 - YES 2 - NO	
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL	BUTE TO CAUSE	OF DEATH YE		UNCERTAIN	1 🗆			_
200	EXAMINER?	HOSPITAL:		OTHER:	_0040.00=0				\dashv
Ĭ,	27. MANNER OF DEATH	28e. DATE OF INJURY	Y 28b, TIME	OF 28c, INJ	5 Residence	8 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCUR	RED	\dashv
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)) INJI		RK? 'ES 2 NO				
	3 Suicide 6 Could not be	28s. PLACE OF INJUI	RY — At home, farm, s	reet, factory, office		281, LOCATION (Street City or Town, State	and Number or	Rural Route Number,	\dashv
ETE	4 Nomicide detarmined		"	Α.		Otty Or Town, Otalio			
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSICIA								
Š	2 MEDICAL EXAMINER:	On the basis of examinat	ion and/or investigation	ı, in my opinion, d	eath occured at the t	time, date and place, a	nd dua to the c	cause(a) and menner as stated.	
296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNI								IGNED (Month, Day, Year)	\neg
0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0									
				Nout		Golden Bea		ad.	
	Vidyasagar Anmanga 31. DATE FILED (Month, Day, Year)	ndla MD 32. Registran's sir	P.O. Bo	x 282 Ch	arlotte	Hall Md. :	20622		_
	JUN 2 7 1995	32. REGISTRAT'S SIG	dear Rardall						



MEDICAL

PHYSICIAN:

BY

COMPLETED

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2

SAEED

31. DATE FILED (Morith, Day, Year)
JUN 2 8 1995

tem

THE HOSPITAL (THE FUNERAL D filed within 72 h TO THE HOSPITAL
TO THE FUNERAL (
be filed within 72 h
IMPORTANT; If II

HOSPITAL

Pages 1, 2, 3 should permit. the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit Mental Hygiene prior to burial, cremation, or removal. Page 6 may be retained by the hospital or attending physician, once. notified at å must medical examiner the t event, the death certificate be executed within traumatic other 6 Health and A any been : . OR ATTENDING PHYSICIAN; The law of DIRECTOR: After this certificate has be hours after death with the State Dept. 0 marked, 28

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Las REG. NO 2. DATE OF DEATH 3. TIME OF DEATH ERNY (Vera Agnes Berry) 0:35 AM JUNE 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign (Month, Day, Year)
May 6, 1909 HOURS 1 - M TO DAYS 379-64-1910 86 Michigan 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Southern Maryland Hospital Clinton Prince George's RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Prince George's Upper Marlboro 1 YES 2 XNO FUNERAL 10a. STREET AND NUMBER 10g, CITIZEN OF WHAT COUNTRY? 9300 Croom Acres Terrace 20772 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 YOU IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuban, Maxicen, Puerto Rican, etc.)

1 YES **[XNO Specify: 14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Married В 3 Widowed 4 Divorced White 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest during most of working (Give kind of work done life. Do NOT use retired.) COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Home Owner 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) Zella BE Elmon Loveland Ambrose 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Gwen Alred 9300 Croom Acres Terrace, Upper Marlboro, MD 20e. METHOD OF DISPOSITION

1 Burtel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State tery, cremetory or other place)
e Crematory June 25, 1995 Clinton, Md 22. NAME AND ADDRESS OF FACILITYLEE Funeral Home, Inc 6633 Old Alexander Ferry RD, Md 2073 23. PART V Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, CONSEQUENCE OF if any, laading to immedieta . Entar UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initisted events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO A.F. COMPLETION OF CAUSE 1 - YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO INCERTAIN I 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL:
1 Dispetient 2 ER/Outpetient 3 DOA OTHER: 1 TYES 2 NO Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide determined 1X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(e) end manner as stated.

29c. LICENSE NUMBER

146260

HILL RJ. SUTTE 200, OXOR

MID

OXON

0168

32. REGISTRAR'S SIGNATURE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

AEE

Kos

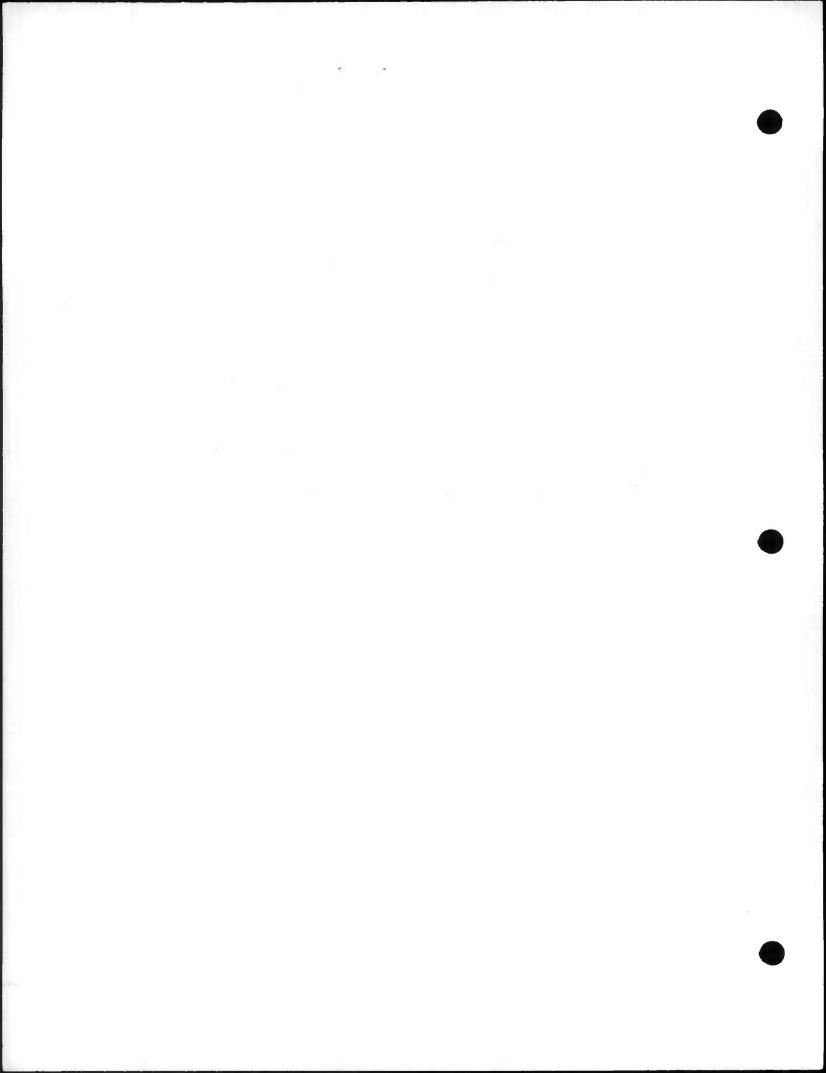
DHMH-16 Rev 1/89

29d. DATE SIGNED (Month, Day, Year)

DIVISION OF VITAL RECORDS, P.O. BOX 68760

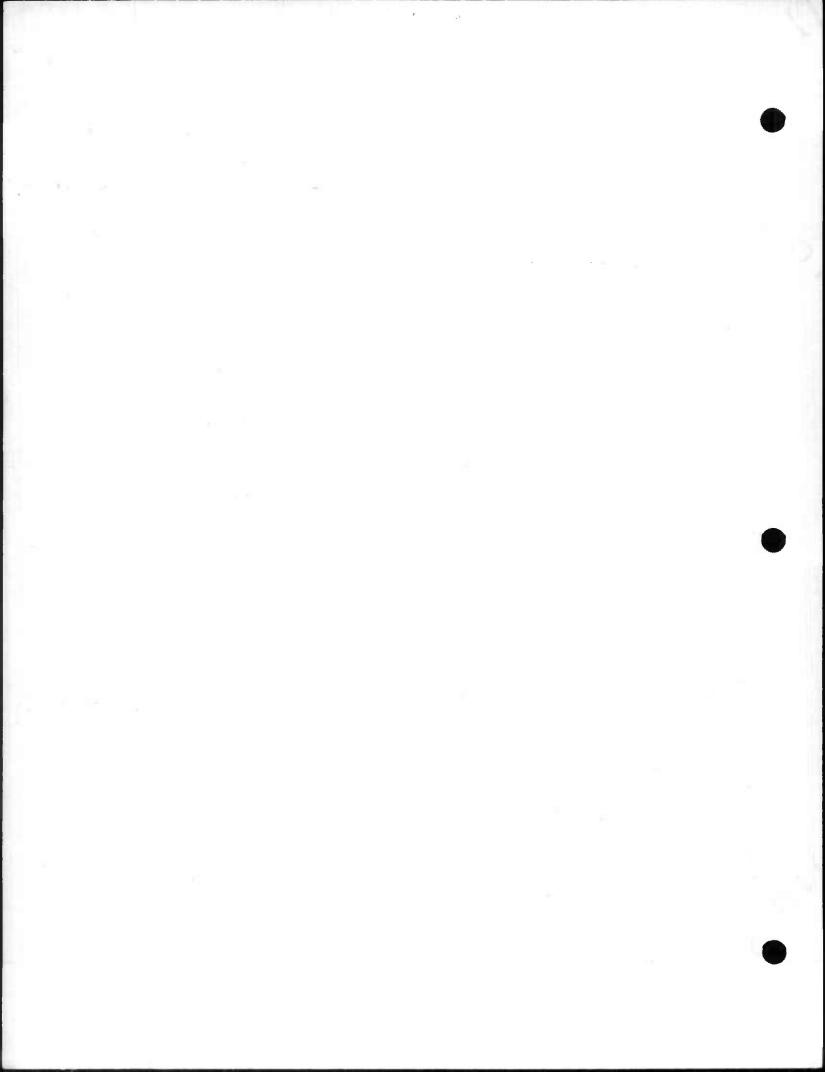
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1 - FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.												
	1. DECEDENT'S NAME (First, Middle, Last)	DULL DOTO				MONT	OF DEATH	AY YE.	3. TIME OF DEATH			
	DOROTHY TRENE 4. SOCIAL SECURITY NUMBER		GEMAN In yrs. lest birthday)	E INDER A VELO	IF UNDER 24 HRS.	_		1995	10:00 AM M			
	2.27/20/20/20/20/20/20/20/20/20/20/20/20/20/	□ M 2 🛛 F 7	4 YRS.	IF UNDER 1 YEAR NONTHS DAYS	HOURS MIN.	Apr.	of BIRTH	s. BIRTNPLACE (State or Foreign Country) North Carolina				
DIRECTOR	2720 Grier Nur				or location of d Forest H			9c. COUNTY	of DEATH Iarford			
REC	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCA	TION				10d. INSIDE CITY			
AL DI	Maryland 100. STREET AND NUMBER	Harford		10	Fore	st H	i11	10a, CITIZEN	LIMITS? 1 YES 2 X NO OF WHAT COUNTRY?			
FUNERAL	2720 Grier Nursery	Road			21	050			USA			
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes, a	CENDENT OF HISPA secify Cuban, Mexic 2 1 NO Speci	an, Puerto	N? (Specify Yes Ricen, etc.)	2	RACE — American Indian, Black, White, atc. Specify: White			
9	15. DECEDENT'S EDUCAT (Specify only highest grade col	TON mpleted)	16a. DECEDENT'S U	rk done durina m	ON ost of working	168	, KIND OF BU	SINESS/INDUSTI				
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life. Do NOT use	retired.)	•							
MO	17. FATNER'S NAME (First, Middle, Last)		Machine	Uperat	16. MOTHER'S NA	AME (First.		anufact	uring			
BE C	John Henry Eff	ler			Lessi			Shehan				
TO .	190. INFORMANT'S NAME (Type/Print) Eula M. Guinn		196. MAILING A 5006		and Number or Rural y Street) 28655 h Carolina			
	20e. METHOD OF DISPOSITION 1 Suriel 2 Cremetion 3 Remove 4 Donation 5 Other (Specify)	il from State 20b.	PLACE AND DATE OF etery, cremetory or othe TOENS OF	DISPOSITION (N	emetery	6/28	20c. LO	cation — city of	or Town, State e, Maryland			
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE)	14	Howard	d K. McC	omas	III F	meral	Home, P.A.			
\dashv	23. PART i. Enter the diseases or con	inplications that caused	the daeth. Do no	11317 (Cokesbur	y Roa	ad, Ab	ingdon,	Md. 21009			
	iMMEDIATE CAUSE (Final disease or condition	Acute Core Due to (or As A	ich lina.					and y and day,	interval Between Onset and Death			
NO		Sequentially list conditions,										
CATI	if any, leading to immediata cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):									
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in daath) LAST	DUE TO (OR AS A	CONSEQUENCE OF):									
	PART II. Other aignificant conditions of	contributing to death by	st mot requising in	Abo and doubt								
PHYSICIAN: MEDICAL	Congestive Heart	tha underlyin	15 10 10			MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?					
Σ	DID TOBACCO USE CONTRIB	LITE TO CALISE OF	E DE ATH VEC	U NO E	UNCERTAI				1 TYES 2 NO			
AN	25. WAS CASE REFERRED TO MEDICAL	2	86. PLACE OF DEATN		UNCERIAI							
/SIC		OSPITAL:		THER:	e 5 K Residence	6 🗆 Othe	r (Specify)					
H.	27. MANNER OF DEATN 1 X Natural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME (URY AT	28d. DES	CRIBE HOW I	JURY OCCURE	D			
B	2 Accident Investigation	n/a 28e. PLACE OF INJURY	n/a	M 1 🗆				n/a				
TED	3 Suicide 8 Could not be 4 Homicide detarmined	building, etc. (Special	n/a	et, factory, offic	factory, office 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) n/a							
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAL CAMBINER: C	N: To the beat of my knowle							se(a) and menner as stated.			
	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI				NED (Month, Day, Year)			
DME D 21809								Tune 24, 1995				
	G. S. Prabhu, M.D				2, Falls	ton,	Md.		410)879-6564			
	31. DATE FILED (Month, Day, Year) JUN 2 6 1995	32. REGISTRAR'S SIGNA	TURE									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans	val.	INSPANDENT IN faces 50 for security of the second factors are added to the second second to the second seco
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THE	표	filed v	TOOR
2	2	2	3

	1 - STATE REGISTRAR	STATE OF N					EALTH A		NTAL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last								DATE OF DEATH MONTH D	AY	YEAR	3. TIME OF DEATH
1	MILTON CHE 4. SOCIAL SECURITY NUMBER								JUNE 22	1994	5	4:20am
		5. SEX	6. AGE (In yrs. le.		IF UNDER 1	YEAR DAYS	HOURS I	Ment	(Month, Day, Year)		8. BIRTH Country	PLACE (State or Foreign
	492 - 09 - 9137 9e. FACILITY NAME (If not institution, give		83	YRS.					eb 29, 19	4		kansas
DIRECTOR		MUNITY H	OSPITAL				R LOCATION				NCE	GEORGE'S C
35	10a. STATE 10b. COUN	TY		10c. CIT	Y, TOWN OR	LOCAT	ION					10d. INSIDE CITY
	Maryland Prin	ce George		Lan	dover	_	ZIP CODE			I so- CIT	TATELL OF M	LIMITS? 1 X YES 2 NO THAT COUNTRY?
FUNERAL	500 N. Harry S.	Truman #1	14			155.7	0785			US		HAT COUNTRY?
1 5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AF	RMED	13. W	_		IISPANIC	ORIGIN? (Specify Yes			- American Indian,
B	t Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1	YES 2 X	NO	111	yes, spe		Mexican, P	ruerto Rican, etc.)		Black Specif	, White, etc.
in the	15. DECEDENT'S ED (Specify only highest grad	UCATION le completed			USUAL OCC				16b, KIND OF BUS	SINESS/INI	-	
Ē	Elementary/Secondary (0-12)	College (1-4 or 5+	- Ma	. Do NOT u	se retired.)	ning mos	et or working					
once.	Grade 8		Mai	inten	ance	Man			Grocer	y St	ore	
COM	17. FATHER'S NAME (First, Middle, Last)						16. MOTHER	'S NAME	(First, Middle, Maiden	Surname)		
ed at	Unknown Cheers								ae Smith			
TO B	19a. INFORMANT'S NAME (Type/Print)								Number, City or Town			
2	Karen A. Martin					_		ebst	er Grove,	MO	63119	9
must	1 Donation 5 Other (Specify)	noval from State	cemetery, cre	matory or o				i	6%26/ 20c. LO	CATION —	City or Tov	vn, Stata
101	21. SIGNATURE OF FUNERAL BERVICE L	CENSEE	1 50.	Pete:	r's Ce		Lery D ADDRESS (OF FACILI	95 Hil	<u>lsda.</u>	le, M	10
mes .	1 6/1/4/0	6/1							ral Home,	P.A		
6	Now HA	23. PART I. Enter the discrete, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, Approximate										
medical examiner	ehock, or heart failure immediate CAUSE (Final	complications that List only one cau	t caused tha de se on eech iins	eath. Do r	not antar th	na mod	fe of dying,	, such a	a cardiac or reapi	ratory an	reat,	Approximata interval Between Onset and Deat
event, the	disease or condition resulting in death)		Seps	S								1
E1												11-3 40
8		DUE TO	(OR AS A CONSE	DUENCE O	F):							4-5 da
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aumatic eve	Sequentially list conditions, if any, leading to immediate	b. DUE TO	OR AS A CONSECUTION OF AS	EN E	F):	nd	ley	, (ilcus			2-3wKs
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31. DATE FILED (Month, Day, Year)

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1995

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physician	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trained within 70 hours after death with the State Death of Health and Mental Holisten and it has completely filled in terminal	examiner must be notified at once.
law requires that the death certificate be executed within hours aft	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the first within 72 hours after death with the State Dent of Health and Mental Horison notes in huital mentaling or removal	IMPORTANT: If I lem 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The	TO THE FUNERAL DIRECTOR: After this certificate has the find within 72 hours after death with the State D	IMPORTANT: If Item 28 is marked, or Item

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH VEAD 1234A M ATHERING ORCORA JUNE 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in vrs. last hirthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. HOURS 1 M 2 F YRS 213-12-0378 87 Apr 12, 1908 Maryland 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH DIRECTOR St. Elizabeth's Nursing Home Baltimore Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Arbutus 1 TES 2XNO FUNERAL 10a STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1251 Sulphur Spring Road 21227 United States 12. WAS DECEDENT EVER IN U.S. ABMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: BY Specify: 3 Wildowed 4 Divorced White 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION ecify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Spe (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Gift Wrapper Retail 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Oliver Lincoln Ebberts BE Helen Swansberry 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Rita Lind 1251 Sulphur Spring Road Arbutus, Maryland 21227 20a. METHOD OF DISPOSITION
1 M Burlel 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State etery, crematory or other place) New Cathedral 4 Donation 5 Other (Specify) 6+28 Baltimore, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Harry H. Witzke Funeral Home Inc. Collins Dum 4112 Old Columbia Pike Ellicott City, 21043 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, **Approximate** ahock, or heert feilura. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Finei disease or condition DUE TO (OR AS, A CONSEQUENCE OF) recuiting in death) 8 = VN CERTIFICATION Sequentielly list conditions. QUE TO (OR AS A CONSEQUENCE OF) if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initieted events resulting in death) LAST PART ii. Other significent conditione contributing to death but not resulting in the underlying cause given in Pert i. 24a. WAS AN AUTOPSY PERFORMEC?? MEDICAL 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 OF DEATH? 1 TYES 2 TNO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🗍 NO [25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 TYES 2 7 NO 1 Inpatient 2 ER/Outpatient 3 DOA ne 5 - Rasidence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME/C 28c, INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1- Natural ВУ 1 TYES 2 NO 2 Accident 3 Suicide 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 8 Could not be determined 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 4 Homicide 29a. CERTIFIER 1- CERTIFYING PHYSICIAN: To th dge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On tigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated 296. SIGNATURE AND TITLE OF CERTIFIER 29C. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, BE 5 6 J 2 5

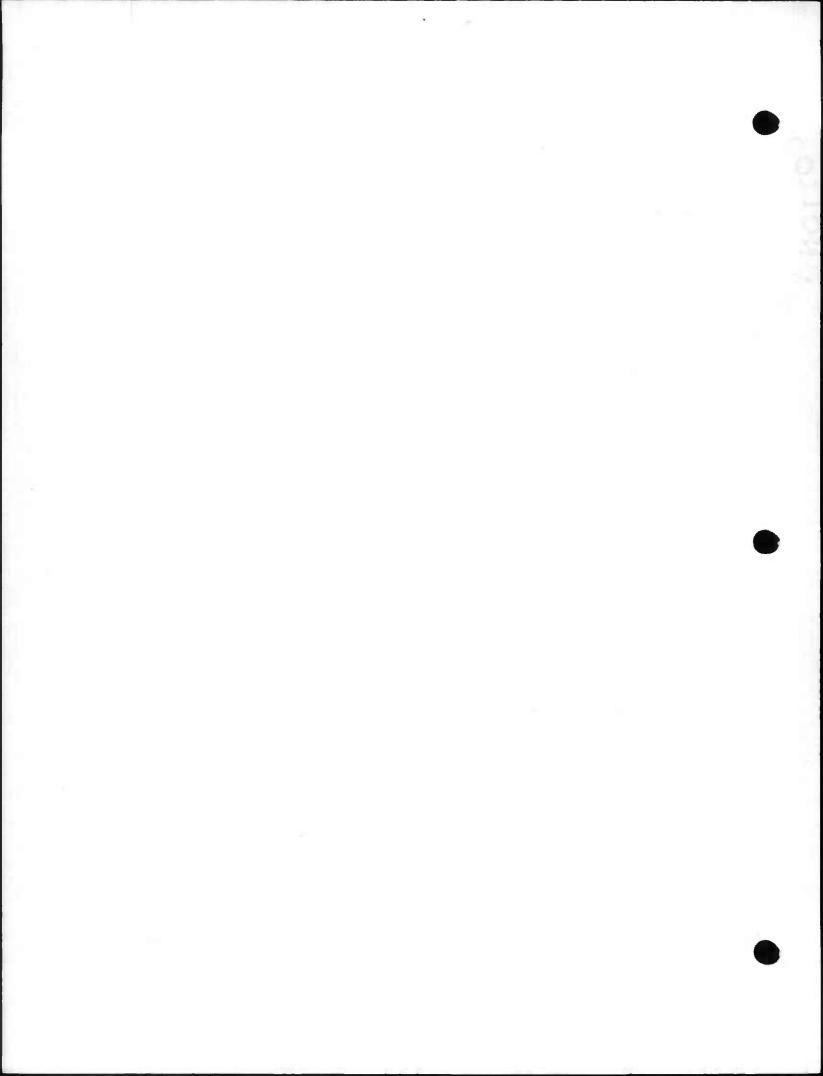
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Tulia Davidson Randall

22. REGISTRAR'S SIGNATURE

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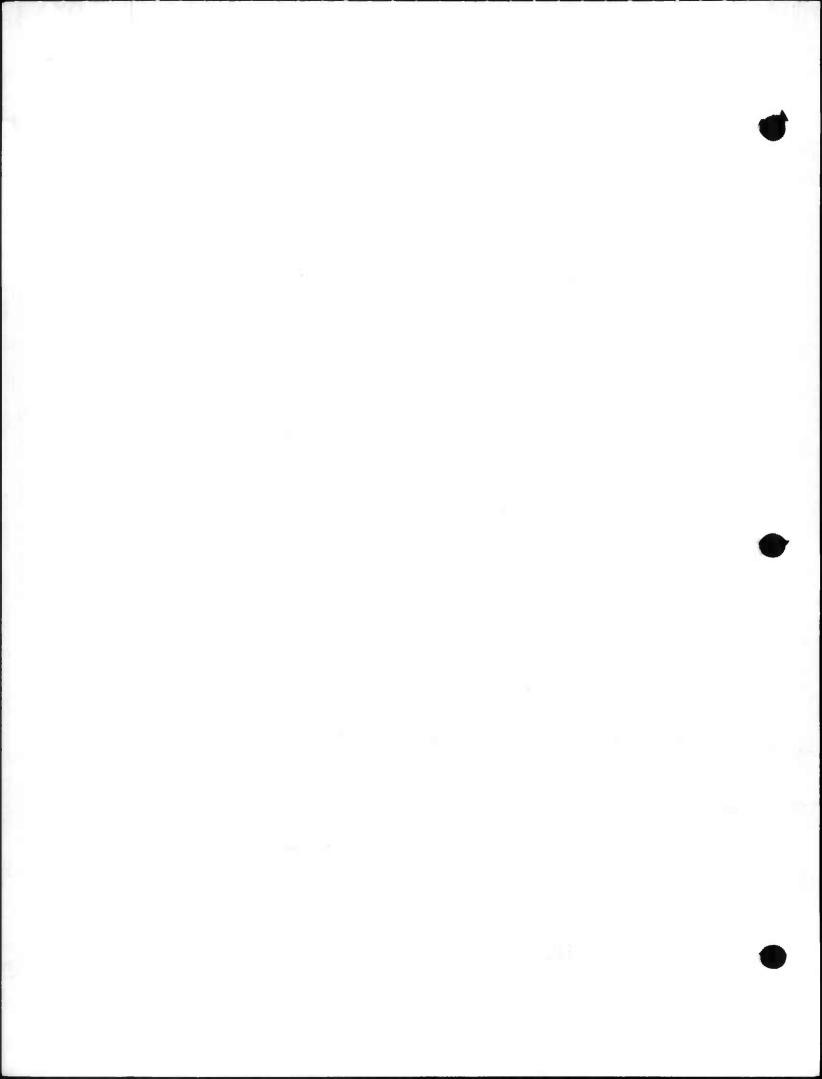
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STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH June 22, 1995 YEAR Ida May CLINE 8:45 PM 4. SOCIAL SECURITY HUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 XF YRS. 217-74-9016 10, 1913 Maryland Aug. use as the burial-transit permit, Pages 1, 2, 3 should 9a. FACILITY HAME (If not institution, give street and number) 9b. CITY, TOWN DR LOCATION OF DEATH 9c COUNTY OF DEATH Northampton Manor Nursing Home DIRECTOR Frederick Frederick RESIDENCE OF DECEDENT 10c. CITY, TOWN DR LOCATION 10d. INSIDE CITY YES 2 NO Frederick Frederick <u>Maryland</u> FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN DF WHAT COUNTRY? 21701 U.S.A. 200 East Sixthteenth Street 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 ND IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC DRIGIN? (Specify Yes or No-If yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 TES 2 NO Specify: BY 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATIOH
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade ĮQ. Elementary/Secondary (0-12) College (1-4 or 8+) 10 Homemaker own home detached once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S HAME (First, Middle, Maiden Surname) 2 F John C. Brust Ruth M. Crummitt BE notified director, page 5 should 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 8129 Yellow Springs Road, Frederick, Md. 21702 Robert L. Cline 99 20a. METHOD OF DISPOSITION
1 Surial 2 Cremation 3 Removal from Stata
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata must Cemetery June 22. HAME AND ADDRESS OF FACILITY 1995 Frederick, Md. Olivet. June 26, 21. SIGNATURE OF FUHERAL SERVICE LICENSES examiner the funeral where Keeney and basford P.A. Funeral Home C-1 M00021 106 East Church St., Frederick, Md. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, filled in by Approximate interval Between shock, or heart failure. List only one cause on each line. 6 IMMEDIATE CAUSE (Final Onset and Death physician and completely fille ne prior to burlal, cremation, traumatic event, the disease or condition PUDUMOMA resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DIVISION OF VITAL RECORDS, P.O. BOX 687 Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury or other DUE TO (DR AS A CONSEQUENCE OF): the attending p that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO Health and shows any DEMONTIA COMPLETION DF CAUSE 1 - YES 2 - NO OF DEATH? HYPER TENSION 1 TYES 2 NO has been of h Dept. of h PHYSICIAN: HOSPITAL OR ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL EXAMIHER? Hem 26. PLACE OF DEATH (Check only one) r this certificate h HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 AND me 5 - Residence 6 - Other (Specify) 6 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26b. TIME OF INJURY marked, 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending investigation 1 YES 2 HO DIRECTOR; After the hours after death v BY 2 Accident 28a. PLACE OF IHJURY — At home, farm, street, factory, office building, atc. (Specify) 90 3 Suicide 281. LOCATIOH (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 28 4 Homicide 29s. CERTIFIER
(Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. TO THE HOSPITAL C TO THE FUNERAL D be filed within 72 ho IMPORTANT; If in 2 MEDICAL EXAMIHER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE \mathcal{L} D 32171 June 1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Richard L. Gough MD 19 Frederick Street, Walkersville, Maryalnd 21793 32. REGISTRAN'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH EVELYN M. CROTHERS June 19, 1995 AR 9:30 $P_{\,\text{\tiny M}}$ 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year NOV . I /) IF UNDER 1 YEAR | IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign 214-10-1059 **DAYS** HOURS 1 M 2 X F 78 Maryland 1916 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DC. COUNTY OF GEATH Meridian Nursing Center DIRECTOR Frederick Frederick RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Frederick Frederick YES 2 NO detached for use as the burial-transit permit. 100. STREET AND NUMBER Meridian Nursing Center FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 400 North Avenue 21701 U.S.A. within 24 hours after death. Page 6 may be retained by the hospital or attending physician. 11 MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-BALTIMORE, MARYLAND 21215-0020 RACE — American Indian, Black, White, etc. II yes, specify Cuban, Mexican, Puerto R

1 YES 2 NO Specify: 1 Never Married 2 Married Specify: White BY 3 🕅 Widowed 4 🗌 Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Spe (Give kind of work done life. Do NOT use retired.) ntary/Secondary (0-12) College (1-4 or 5+) 7 years Homemaker None Once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) John L. Wynn 2 To Nettie F. Sallosto BE notified funeral director, page 5 should 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Doris Main 286 Dill Avenue Frederick, Maryland 21701 pe 20a METHOD OF DISPOSITION

1 Buriel 2 Cremellon 3 Removal from State 20b. PLACE AND OATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stata DATE must Mount Olivet Cemetery 6/23 Frederick, Maryland 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUN ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST. FREDERICK, MD 21701 this certificate has been signed by the attending physician and completely filled in by the it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, irked, or Item 23 shows any Injury, or other traumatic event, the medical ex Enter the diseases, or complication that clased shock, or heart failure. List only one cause on 23. PART I. Enter the disea e death. Do not anter the mode of dying, such as cardiac or respiretory arrest, Interval Between Onset and Death **IMMEDIATE CAUSE (Final** disesse or condition resulting in death) neumonus June 95 OUE TO (OR AS A CONSEQUENCE OF): CVA executed CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate Pe cause. Entar UNDERLYING requires that the death certificate CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AWAILABLE PRIOR TO DERYDRAMON COMPLETION OF CAUSE DF DEATH? 1 TYES 2 NO 1 TES 2 NO PHYSICIAN: WE 25. WAS CASE REFERRED TO MEDICAL 26: PLACE OF OEATH (Check only one) HOSPITAL OTHER: 1 TES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ng Home Realdence 8 - Other (Specify) 27. MANNER OF DEATH 26a, DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. OESCRIBE HOW INJURY OCCURED is marked, 5 Pending Investigation 1 Natural L DIRECTOR: After the hours after death w M 1 YES 2 NO BY 2 Accident OR ATTENDING 28s. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be COMPLETED 28 4 Homicide Tem CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. FUNERAL I IMPORTANT: If 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE THE FIED asag 40307 June 20, 1995 2 2 3 0 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 30. NAME AND ACCRESS OF PERSON Eugene B. Casagrande MD Parkview Medical Group Frederick, MD 21701 32. RESISTRAND SIGNATURE 31. DATE FILED (Month, Day, Year)

JUN 2 1 1995

be detached for use as the burial-transit attending physician. BALTIMORE, MARYLAND 21215-0020 be retained by the hospital or funeral director, page 5 should Раде 6 тау hours after death. n by the f filled in by 0 cremation. completely executed burlal, and 0 attending physician 8 prior

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JUNISION OF VILAL RECORDS, P.O. BOX 68760	DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within
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DIRECTOR: after 28 |

95 20601 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 2. DATE OF DEATH CrAIG Lyburn EdWIN June 1795 6. AGE (In yrs. last birthday) A SOCIAL SECURITY NUMBER IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH S. BIRTHPLACE (State or Foreig Month, Day, (bar)
112. 27, 1916 HOURS 218-03-7071 1X M 2 | F DAYS YRS Aug. Maryland 9a. FACILITY NAME (If not institution, give stre 9b. CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Harford Methorial Hospital Havre de Grace Harford RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Cecil Port Deposit 1 X YES 2 NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 82 South Main Street 21904 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yee, specify Cuban, Mexican, Puerto Rican, stc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married ΒY Specify: 3 Widowed 4 Divorced White COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Wiley Manufacturing Company intery/Secondary (0-12) College (1-4 or 5+) Port Deposit, Maryland Twelve Years Personnel Department -----17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) James V. Craig Isabella Duke BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Helena E. Craig 82 South Main Street, Port Deposit, Maryland 21904 20s: METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Hopewell Cemetery 4 Donation 5 Other (Specify) 6/24/95 Port Deposit, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Lee A. Patterson & Son Funeral Home THENDIN Perryville, Maryland 23. PART i. Entar the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardisc or respiratory arrest, Approximate shock, or haart allura. List only one cause on each line. intarval Between IMMEDIATE CAUSE (Final Onset and Dasth disease or condition Cardiac arrhytamia minutes resulting in death) DUE TO (OR AS A CONSEQUENCE OF 15-20 4 cars DUE TO (OR AS A CONSEQUENCE OF): Treat CERTIFICATION Sequentially list conditions, if any, leading to immediate Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in daath) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER: 1 YES 2 NO 4 - Nursing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending м 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end manner es stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Enger E. Bellia, MO. mo- D4006 ► 6/22/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Edgar E. Folk, III, M.D., 118 North Street, Suite 3A, Elkton, Maryland 21921

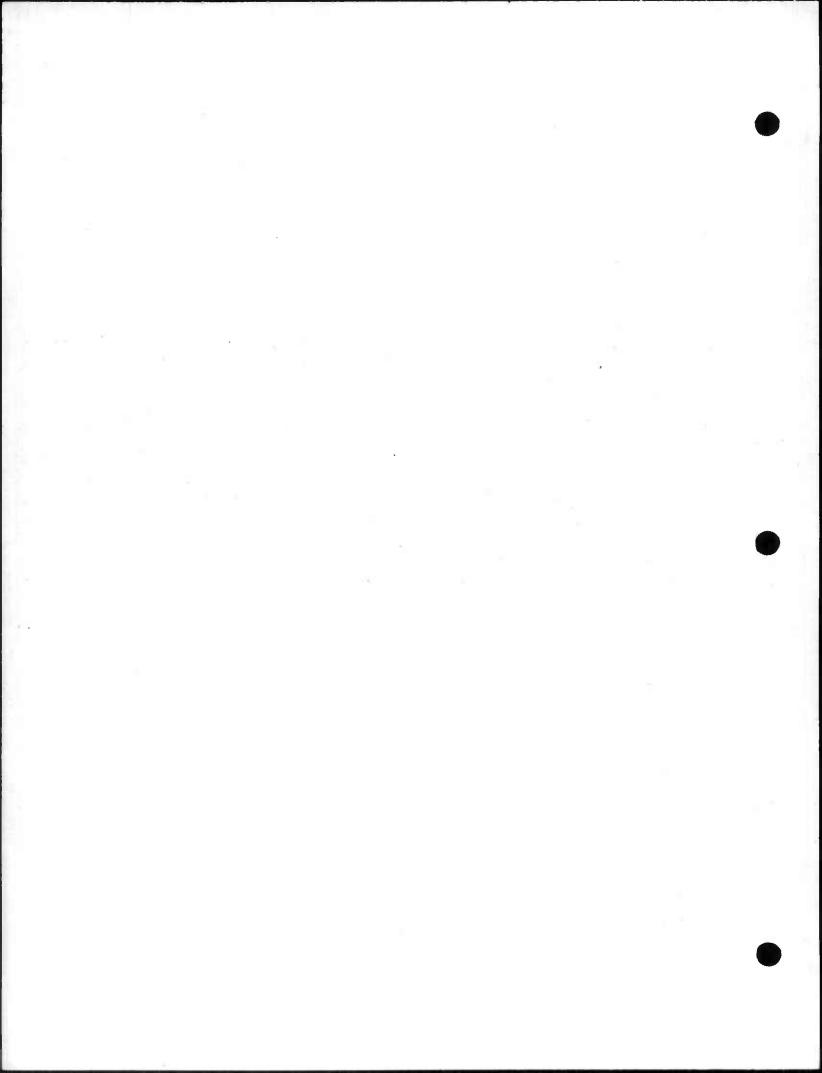
29e. CERTIFIER

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CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated.

32. BEGISTRARE SIGNATURE PORTELL

281. LOCATION (Street end Number or Rural Route Number, City or Town, State)



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2. REGISTRAR'S SIGNATURE

JUN 23 1995

	REGISTRAR	ERTIFICATE OF	- DEATH	REG. NO.	
	1. DECEDENT'S NAME (First, Middle, Last)	2	2.	DATE OF DEATH	year 3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGF (In year)		J	UNK 20	1995 7.32
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. II M 2 (X.F.) 99		HOURS MIN.	DATE OF BIRTH (Month, Day, Year)	BIRTHPLACE (State or Foreig Country)
	9e. FACILITY NAME (If not institution, give street and number)		OF LOCATION OF DEATH		5 Hodges,S.C
E .	SOUTHERD MANYLAND HOS.		UTON	-	-
CTOR	RESIDENCE OF DECEDENT				YNCE GRONGE
DIREC	D.C. 10b. COUNTY none	Washi	ngton		10d. INSIDE CITY LIMITS?
AL C	10e. STREET AND NUMBER		IOF. ZIP CODE	100	CITIZEN OF WHAT COUNTRY?
ER	5232 North Capital St. N.W		2001	7	U.S.A.
FUNER	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. A	ARMED 13. WAS D	ECENDENT OF HISPANIC O	RIGIN? (Specify Yes or No	- 14. RACE - American Indian
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E0 B					Specify Black
ETE	(Specify only highest grade completed)	DECEDENT'S USUAL OCCUPA: (Give kind of work done during in ife. Do NOT use retired.)	TION most of working	16b. KIND OF BUSINESS	INDUSTRY
	Elementary/Secondary (0-12) College (1-4 or 5 +) "	Maid		Domestic	
COMP	17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Sumen	ne)
ш	Peter Brownlee		Ma	ry Will	iams
TO B		19b. MAILING ADDRESS (Stree			
					ille,Md.2071
	1 N Buriel 2 Cremation 3 Removal from State cemetery, c	EAND DATE OF DISPOSITION (crematory or other place)			— City or Town, State
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	t Lincoln	Cemetery	γ	
	17 Romand Ment	1 40	0 0411 01		eral Home
	23. PART I. Enter the diseases, or complications that caused the	testh Do not enter the s	U 34th St	.S.E.Wash	.D.C.20020
	shock, or haart fellure. List only one cause on each lir	ne.	out of dying, addit on	cardiac or reapmatory	Approximate interval Betwoen Onset and D
	disease or condition resulting in death)	arrellery	ila.		Oliset slid D
	DUE TO (PR 1.S A CONS	EQUENCE OF			
ATION	Sequentially list conditions,	Docenses	ria		
ATIC	if smy, lasding to immediate cause. Enter UNDERLYING	EOUENCE OF:	Anthre	2	
CERTIFICATION	CAUSE (Disease or Injury	EOUENCE OF):	years ac		
RTIFI	resulting in death) LAST		1		
	PART II. Other significant conditions contributing to death but not	regulting in the underlyi	De course alves la Bost		
EDICAL (resulting in the underlyi	ng cause given in Part	PERFORMED?	AWAILABLE PRIOR TO
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V: ME	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DE	ATH YES NO	Z UNCERTAIN [٦	1 TES 2 NO
SICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLA	ACE OF DEATH (Check only on			
YSI	1 ☐ YES 2 NO 1 Dentation 2 ☐ ER/Outpatient	3 DOA 4 Nursing No	rne 5 🗆 Reeldence 8 🗆	Other (Specify)	
ву РНУ	27. MANNER OF DEATH 1 Netural 5 Pending 28s. DATE OF INJURY (Month, Day, Year)	INJURY V	JURY AT 28d	. DESCRIBE HOW INJURY	OCCURED
B√	2 Accident Investigation		YES 2 NO		
8	3 Suicide 6 Could not be datermined 28e. PLACE OF INJURY — At h	nome, farm, street, factory, off	lce 281.	LOCATION (Street end Nun City or Town, State)	nber or Rural Route Number,
LET	290. CERTIFIER	ata a sanga a sanga da a sanga			
COMPL	Check only ones of the best of my knowledge, of the best of my knowledge, of the best of my knowledge, of the best				
	290. MONATURE AND TITLE OF CERTIFIER	ATT 1	29c. LICENSE NUMBER		
	and grante originals in the continue of			29d.	DATE SIGNED (Month, Day, Year)
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ш	60 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (IT	Allware	8-24:	535	21 June 199

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be renained by the hospital or arranding observed.

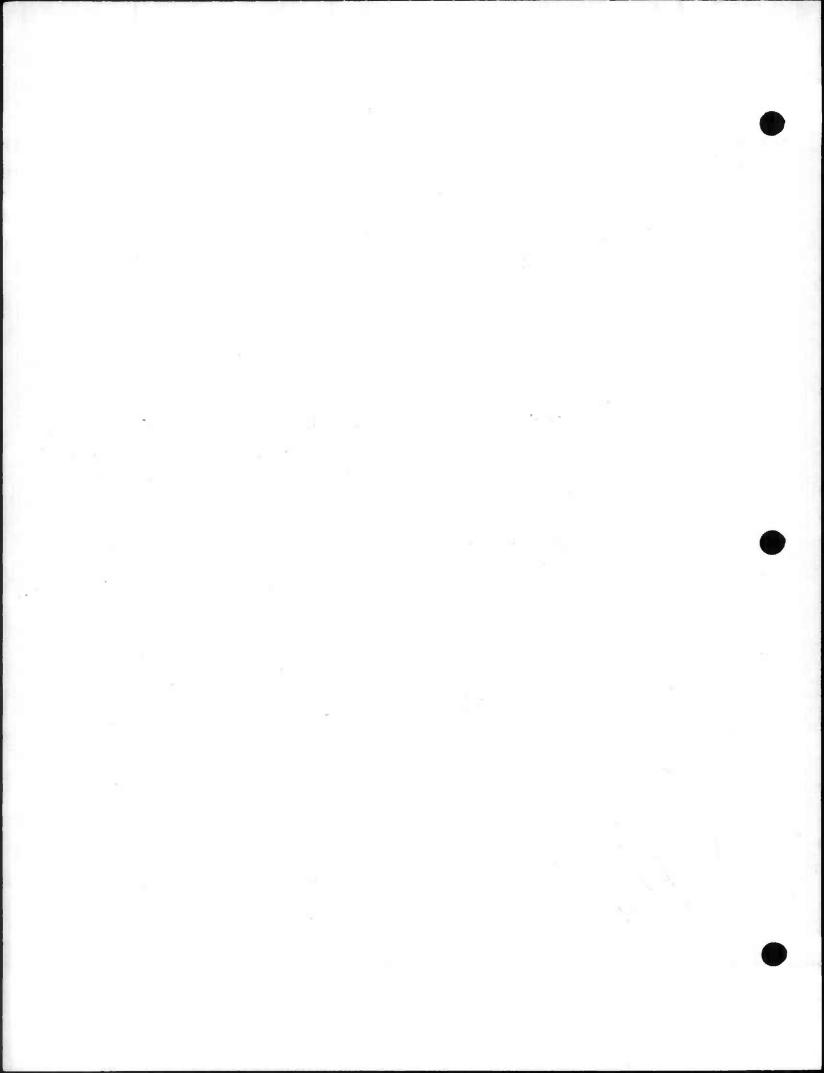
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 Is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	HEGISTHAH		- CI	EKIIF	CAIC	UF	DEA	l III	F	IEG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF				3. TIME OF DEATN
	Ann Elizabeth	COMMETI							June.	15.	1995	YEAR	0324AMM
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. las	t hirtholms	IF UNDER	4 VEAR	IF UNDER	04 1400	7. DATE OF		1993		
					MONTHS	DAYS	HOURA	MIN.	(Month, De	y. Year)		Count	
	221-18-4556	1 🗌 M 2 🔀 F	63	YRS.					Feb :	, 1	932	Wilmi	ngton, Delaware
	9e. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY,	TOWN C	R LOCATI	ON OF DE	ATN		9c. COL	INTY OF D	DEATN
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DIRECTOR	10a. STATE 10b. COUNTY	r		10c. CIT	Y, TOWN O	R LOCAT	IDN						10d, INSIDE CITY
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	MD Princ	e Georg	e s	MIT	che								1 TES 2 NO
FUNERAL						101	ZIP COD	E			10g. CIT	IZEN OF	WHAT COUNTRY?
	10506 Meadow R	idge La	ne				2072	21			U	. S . F	۸.
5	11. MARITAL STATUS	12. WAS DECEDENT			13. \	MAS DEC	ENDENT C	F NISPAN	IC DRIGIN? (S	pecify Yee	or No-	14. RACI	E — American Indian, k, White, etc.
	1 Never Merried 2 Merried	FORCES? 1	YES 2 7	ND.		f yes, spi	2 PNO	n, Mexice	n, Puerto Rica	n, etc.)			
84	3 Widowed 42 Divorced		UI DII DAILG		- 1 -	_ res	2 [] 100	Specify				Spec	Black
0	15. DECEDENT'S EDUC	CATION	16e. DE	CEDENT'S	USUAL OC	CLIPATIO	M		14b VIII	D OF BUS	INCOCURN	DUCTON	DIACK
	(Specify only highest grade	completed)	(G	ive kind of v Do NOT us	work done o	furing mo	st of working	g	100. (1)	D OF BUS	HAC22/IM	DUSTRY	
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E		4yrs	Com	pute	er A	amı	n .su	ervi	31 0r . (ove	rnm	ent	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTI	HER'S NAI	ME (First, Middl	e, Maiden	Sumame)		
BE (Fred Johnson						F	Haze	1 0	MCNA	IR		
	19a. INFORMANT'S NAME (Type/Print)		191	. MAJLING	ADDRESS	(Street o	nd Number	or Rural F	loute Number, (-		n Codel	
임	Shawn A. Conn	011											20721
								OGE_	LANE				LLE MD
	20a, METHOD OF DISPOSITION 1	oval from State	20b. PLACE / cemetery, cre			TION (Na	me of		DATE	20c, LO	CATION -	City or To	wn, State
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- 1	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	1		22.1	NAME AN	D ADDRES	S OF FAC	Fune			J1(/	
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	Million	Wa	1 July	MOY	74	74	Land	love	r RD.	La	ndo	ver,	Md. 20785
	23. PART i. Enter the diseesea, or o	complications that	ceused the de	ath. Do n	ot enter	the mo	de of dyl	ng, auct	aa cerdiac	or reapli	ratory ar	rest,	Approximata
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- 1	disease or condition	. A. Lens	1410.1		-	1	A	1		1		1./	/ a A
	reaulting in death)	They was	-www	MA	elin	ML	600	ucci	Juna	100	1764	cov a	Helice
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Z	Sequentially list conditions,	b											
CERTIFICATION	if any, leading to immediate	DUE TO (OR AS A CONSE	UENCE OF):								
8	CAUSE (Disease or Injury	£.											
E	that initiated events	DUE TO (OR AS A CONSE	UENCE OF):								
E 1	resulting in death) LAST												
8		d											
	PART II. Other significant condition	a contributing to	death but not r	eaulting I	n the un	deriying	ceuse g	Iven in I	Part i. 24s	. WAS AN	AUTOPSY	24b	. WERE AUTOPSY FINDINGS
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End dulysis regimen, distriling melliling							AVAILABLE PRIOR TO						
ō	PALLET	regimen	1 des	eng	me	llu	40		10	YES 2	MO NO		AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
MEDICAL	D.1. 1. Low #	10	115	L	me	Ш	no		1[YES 2	₽ NO		COMPLETION OF CAUSE
Ξ	Reght /selow the	18nu a	mpete	۷.	SON		/	ERTAIN		YES 2	₽ NO		COMPLETION OF CAUSE DF DEATH?
Ξ	DID TOBACCO USE CONTR	18nu a	ISE OF DEA	۷.	s 🗆 N	10 🗷	/	ERTAIN		YES 2	₽ NO		COMPLETION OF CAUSE DF DEATH?
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	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND 27. MANNED OF DEATH	PRILL OF CALL	26. PLACER/Outpatient 3	TH YE	S N N (Check of OTHER 4 Num	NO P	UNC			ecify)		CURED	COMPLETION OF CAUSE DF DEATH?
PHYSICIAN: MI	DID TOBACCO USE CONTROL 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND 27. MANNER OF DEATH 1 Netural 5 Pending	RIBUTE TO CAL HOSPITAL: 1 Inpetient 2 M	26. PLACER/Outpatient 3	TH YE E DF DEAT DOA 28b. TIM	S N N (Check of OTHER 4 Num	nnly one) I: Ing Home 28c, INJI	UNC	sidence	8 Other (Sp	ecify)		CURED	COMPLETION OF CAUSE DF DEATH?
BY PHYSICIAN: MI	DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	HOSPITAL: 1 Inpetient 2 M 26e. DATE OF (Month, De) 26e. PLACE DF	26, PLAC ER/Outpatient 3 NJURY (, 19ar)	TH YE E DF DEAT DOA 28b. TIMI	S N N (Check of OTHER 4 Number OF URY M	only one) I: ling Home 28c, INJU WOI 1 Y	UNC 5 Re JRY AT RK? ES 2	sidence	8 Other (Sp 28d. DEŞCRII	ecify) BE HOW IN	JURY OC		COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
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E COMPLETED BY PHYSICIAN: MI	DID TOBACCO USE CONTI	HOSPITAL: Impetient 2 br 28e. DATE OF Information	26, PLAC ER/Outpatiant 3 NJURY — At horic. (Specify) my knowledge, de	TH YE E DF DEAT DOA 28b. TIME INJ THE TIME THE T	M (Check of OTHER 4 Nurse of OTHER 4 Nurse of OTHER 4 Nurse of OTHER 4 Nurse of OTHER 1 Nurse of O	nily one) i: iling Home 28c, INJI WO 1 Y Pory, office	UNC 5 Re JRY AT RK? ES 2 end plece, eath occurr	ND end due	8 Other (Sp 28d. DESCRII 28d. LOCATID City or To	ecity) BE HOW IN N (Street e wn, State)	IJURY OC	r or Rural F	COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO Route Number,
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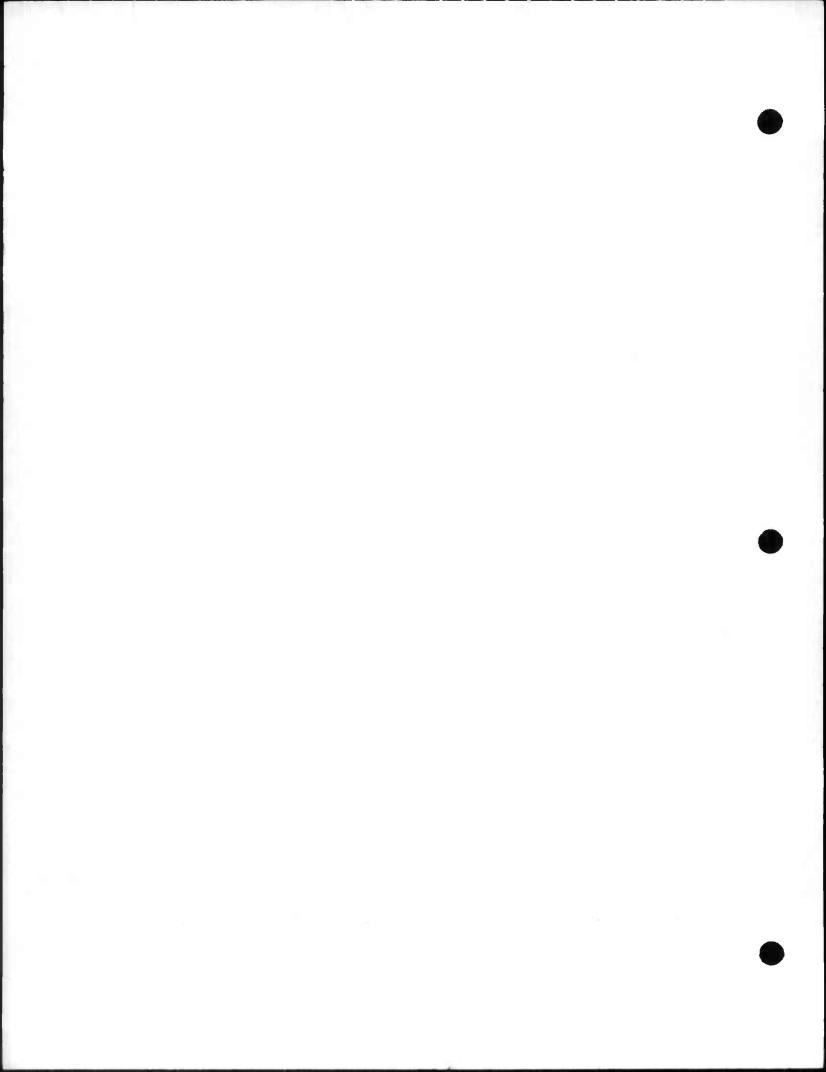
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TOTHE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYL		MENT OF H		MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)		O/11 E O1	DEATH	2. DATE OF DEATN	.,	3. TIME OF DEATN		
	LEO FILSWORTH CHITT	AMS SR)		June 1		6:40 a ^M		
		(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN (Month, Day, Year)	8.1	BIRTHPLACE (State or Foreign		
	214-32-8975 1 M 2 F 5	9 YRS.	9b. CITY, TOWN O	HOURS MIN.	June 20, 19		aryland		
DIRECTOR	7742 Bender Road		Palmer		LAIN		ce George's		
350	10s. STATE 10b. COUNTY	10c. CITY,	TOWN DR LOCAT	ON			10d. INSIDE CITY		
	MD Prince George's	Pal	mer Pa	rk			LIMITS?		
AL	10e. STREET AND NUMBER		101.	ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?		
E I	7742 Bender Road			20785		U.S.	A.		
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D.	2 10	II yes, spe		NIC ORIGIN? (Specify Yean, Puerto Rican, stc.)		RACE — American Indian, Black, White, etc. Specify:		
	15. DECEDENT'S EDUCATION	18a. DECEOENT'S U	ICHAL COCURATIO				Black		
COMPLETED	(Specify only highest grade completed)	(Give kind of wo	ork done during mos	n t of working	16b. KIND OF BU	SINESS/INDUST	RY		
PLE	Elementary/Secondary (0-12) College (1-4 or 5+) 12th	Housek			Gover	omon+			
OM	17. FATNER'S NAME (First, Middle, Last)	Housek	eeper	18. MOTHER'S NA	AME (First, Middle, Maiden				
	Francis Chittams			Viola		our terrey			
BE (19a. INFORMANT'S NAME (Type/Print)	19b. MAILING A			Route Number, City or Tow	n. State. Zio God	fel		
5	Wilma Chittams / WIFE				almer Pa:				
	20a, METHOD OF DISPOSITION 20b	PLACE AND DATE OF	DISPOSITION (Nat		1995 20c. LO	CATION - City	or Town, Slate		
	4 Donation 5 Other (Specify)	retery, crematory or other	erplace) emoria	1 Park	Junio La	andove	r.MD		
ì	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	-1	22. NAME AN	ADDRESS OF FA	CILITY				
	· Inawara of Bl	axton	7474	Landov	s Funera: er Rd. La	andove	er, Md.		
	23. PART i. Enter the diseases, or complications that caused shock, or heart fallure. List only one cause on a	tha death. Do no	t antar tha mod	a of dying, aud	ch ss cardiac or reap	ratory srreat,	Approximate Interval Between		
	IMMEDIATE CAUSE (Final						Onset and Death		
	disesse or condition resulting in death) s	I	RENAL I	AILURI	2				
	DUE TO (DR AS A	CONSEQUENCE OF):							
NO O	Sequentially list conditions.								
F	If any, lasding to immediata cause. Enter UNDERLYING	OUE TO (OR AS A CONSEQUENCE DF):							
CERTIFICATION	CAUSE (Disease or Injury C.	CONSEQUENCE OF):							
	resulting in death) LAST						İ		
	G								
¥.	PART II. Other significant conditions contributing to death b	ut not rasulting in	tha underlying	cause givan in	Part I. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO		
음	<u>Dialysis, past 1 day</u>				1 _ YES 2	©XNO	COMPLETION OF CAUSE OF DEATN?		
≝							1 TYES 2 NO		
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE O	F DEATH YES		UNCERTAI	N 🗆				
<u> </u>	EXAMINER? HOSPITAL	26. PLACE DF DEATH	(Check only one)						
× ×	1X YES 2 ND 1 Inpatient 2 ER/Outp	etlant 3 DOA 4	Nursing Home	5X) Residence	8 Other (Specify)				
	27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Dey, Year)	28b. TIME INJUI	RY WOF	K?	28d. DESCRIBE NOW I	NJURY OCCURE	ED		
B	2 Accident Investigation			S 2 ND					
COMPLETED	3 Sulcide S Could not be determined 28e. PLACE DF INJURY building, etc. (Spec	— At home, farm, str ify)	eel, factory, offica		281, LOCATION (Street : City or Town, State)		ural Route Number,		
7	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowl	edge, death occurred	at the time, data :	nd place, and due	to the cause(s) and mar	nner as stated.	And the second		
S	one) 2 MEDICAL EXAMINER: Dn the besis of examination						use(s) and manner as stated.		
ш	BILL SUCHATURE AND TITLE OF CERTIFUER		T	29ga,LICENSE NUI	WINER	294. DATE SIG	INED (Month, Day, Mar)		
œ	Thugus to F. Andura	UN MI	7	4219	30 .	£	24.1000		
요 (30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE	ATH (ITHM 27) (Type, P	MHD . O	1		WILL.	11/100		
	Mileus to P. Kadurue hu	5009	7 Kays	Rung C	Coon	MA	207116		
	21. DATE FILED (Month, Day, Year) 22/ REGISTRATES SIGNA	Artine	1 //	- 7 25 - 7	1	PW	20148		
	JUN 22 1995 your davidge Road	11			81 =1.50				



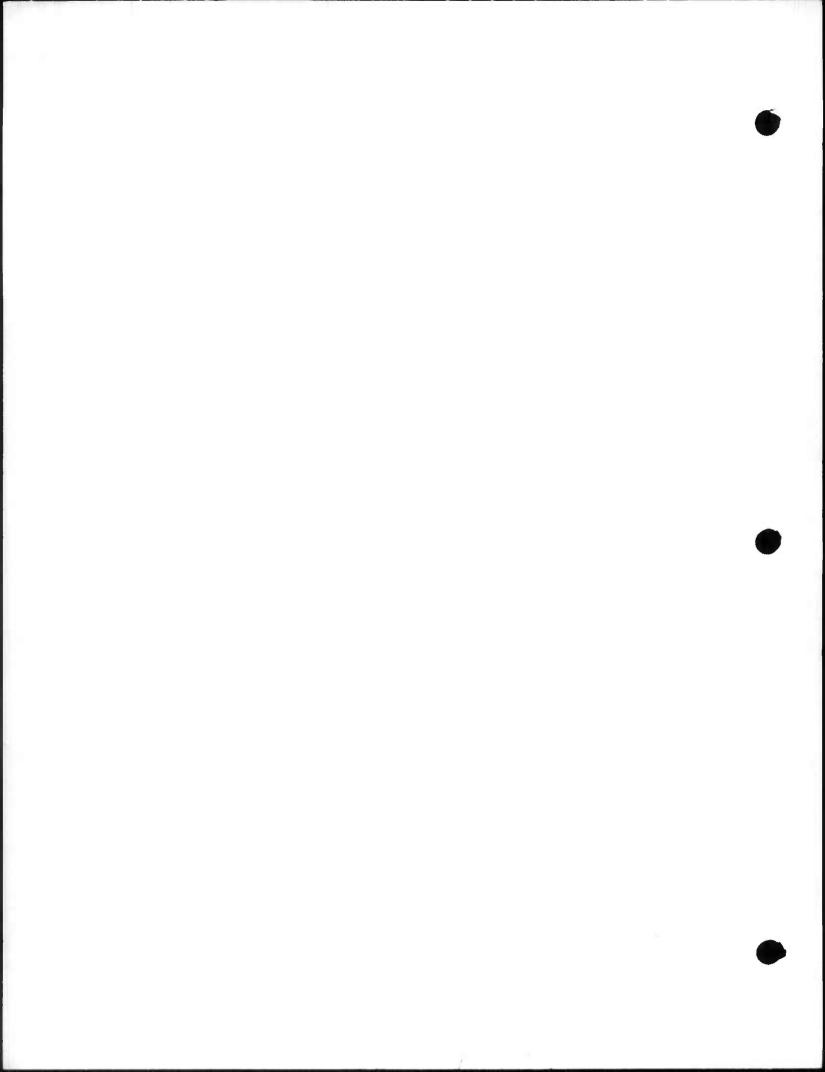
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an increase of each. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR

	1 - STATE REGISTRAR	SIAIE UF M					DEATH AND	MEN I/	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)							2. DAT	E OF DEATH			3. TIME OF DEATH
		Jeanett	e D.	Co	wles			Jun	e 19,	1995	YEAR 3	3:00 A.M. M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	**	IF UNDER	1 YEAR	IF UNDER 24 HRS.	7. DATI	E OF BIRTH		a. BIRTHPL Country)	LACE (State or Foreign
	167 16 2535	1 □ M 2 😾 🛣	84	YRS.				May	28, 19	911		nsylvania
œ	9a. FACILITY NAME (If not institution, give s				96. CITY,	TOWN C	OR LOCATION OF D	EATH		9c. COU	NTY OF DEA	ATH
ᅙ	3928 Winchester I	Jane				Bow	ie			Pri	ince (George's
DIRECTOR	10e. STATE 10b. COUNT	Υ		10c. CIT	Y, TOWN O	R LOCAT	TION				1	od. INSIDE CITY
	Maryland Princ	ce George	s	1	Bowie						1	LIMITS?
¥	10e. STREET AND NUMBER				_	101	. ZIP CODE			10g. CIT	IZEN OF WH	AT COUNTRY?
FUNERAL	3928 Winchester I						20715				ited S	tates
ᇍ	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT FORCES? 1	YES 2 W				ENDENT OF HISPAI ecify Cuben, Maxico			or No-	14. RACE - Black, 1	- American Indian, White, atc.
8	3 ₩ Widowed 4 Divorced	IF YES, GIVE W		No	1	YES	2 ND Specif	ty:	No		Specify:	White
	15. DECEDENT'S EDU		16a. DE	CEDENT'S	USUAL OC	CUPATIO	ON	16	b. KIND OF BUS	SINESS/INI	DUSTRY	WILLE
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)		Do NOT u	work done o	during mo	st of working					
₩ W	12		1	lomen	naker				Own Ho	ome		
ତ୍ର	17. FATHER'S NAME (First, Middle, Last)						16. MOTHER'S NA	AME (First,	Middle, Malden	Surname)		
8	Edward J. Danks						Janet 1					
임	Robert Kent Cowle						nd Number or Rural					
1	200. METHOD OF DISPOSITION	:5	20b. PLACE A				er Lane				City or Town	
	1 Duriel 2 Cremation 3 Rem	oval from State	cemetery cre-	metary or o	ther plecel		natory 6	1				ia Va.
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			22.1	NAME AN	D ADDRESS OF FA	CILITY				
	* Robert &	Carin	in t	7			E. Evar					
	23. PART I. Enter the diseases, Dr	omplications that	caused tha da	ath. Do i	not antar	the mo	Annapol:	ch aa ce	d . BOW]	ratory ar	rest,	Approximate
ļ	ahock, or haart feliure. IMMEDIATE CAUSE (Final	List Dniy Dne ceus	e Dn each line	•								intarval Between Onset and Death
	disease Dr condition resulting in death)	. the	umon	ia								
	,	-		ONSEDUENCE OF):								2 weeks
Z	Sequentially list conditions,		physe,									years
RTIFICATION	if any, leading to immediata cause. Enter UNDERLYING	DOE TO (OR AS A CONSEC	DUENCE O	F):							
	CAUSE (Disease or Injury that initiated events	c DUE TO (DR AS A CONSEC	DUENCE D	F):							
H	reaulting in daeth) LAST	d										
3	PART II. Other algolificant condition	a contributing to	faath but not n	esulting	in the un	derivino	r cause alvan in	Dart I	24a, WAS AN	ALCTORON	7 245 14	/ERE AUTOPSY FINDINGS
<u>8</u>	Connective	1.	Osteox		· ·	aurry mg	y vadou givan in	7 411 1,	PERFOR	MED?	A	WAILABLE PRIOR TO
MED		1							1 🗆 YES 2	MO	D	F DEATH?
2	DID TOBACCO USE CONTI	RIBUTE TO CAL	JSE OF DEA	TH YE	S III	NO [UNCERTAI	N \square			1 '	L TES 2 L ND
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLAC	E OF DEA	TH (Check o	-						
25	1 TES 2 ND	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER	t: Ing Hom	e 5 Residence	8 🗆 Oth	er (Specify)			
PHY	27. MANNER DF DEATH 1 Nsturel 5 Pending	28a. DATE OF I (Month, Da	NJURY (, Year)	28b. TIM	E OF JURY	28c. INJ WO	URY AT RK?	28d. DE	SCRIBE HOW II	NJURY OC	CURED	
2	2 Accident Investigation				М		ES 2 NO					
ED	3 Suicide S Could not be 4 Homicide determined	bullding, a	INJURY — At hor tc. (Specify)	me, farm, :	street, facto	ory, offici		281. LO	CATION (Street a y or Town, State)	ind Number	r or Rurel Rou	ite Number,
COMPLEIED	29a. CERTIFIER				-		-10		100			
Ž	(Check only one) 1 CERTIFYING PHYSI 2 MEDICAL EXAMINE	R: On the best of s										
	29b. SIGNATURE AND TITLE DF CERTIFIER						29c. LICENSE NUI		a the place, are			
2	Unumari	h mo										Month, Day, Year)
2 ∥	30. NAME AND ADDRESS OF PERSON WH						D 4699			6	1 = 0 1 0	
	Tara T. Musc	wich	43006	alla	A FR	x L	a, Suite	-118	Bowli	Z K	iD a	10715
	JUN 21 1995	32. REGISTRAF	CSIGNATURE						.c.cv/	/		113
	1014 WT 1222 VW											- 1

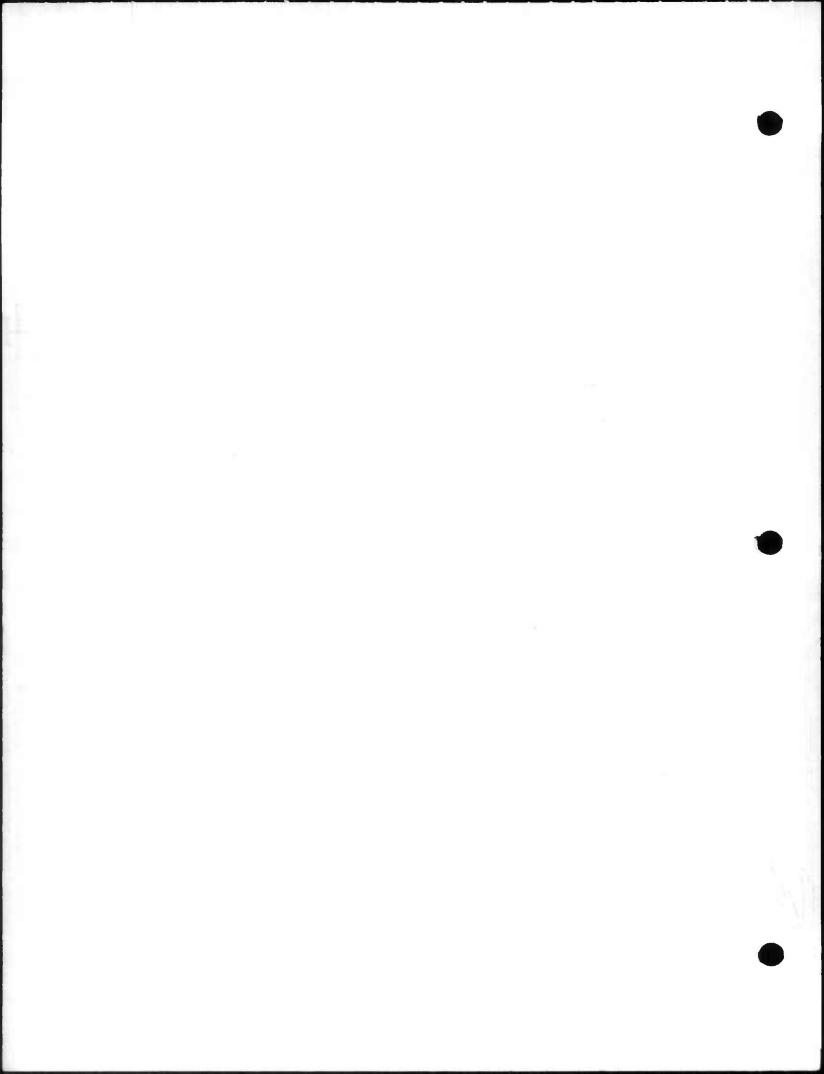


DIVISION OF VITAL RECORDS, P.O. BOX 68760

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1	뽀	뽀	20	OR
1	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an hours a	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in b	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or ren	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medi-
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age 6 may be retained by the hospital or attending physician. director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	ir must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR	900 FRI 100
NG PHYSICIAN: The law requires that the death certificate be executed within. A hours after death. Page 6 may be retained by the hospital or attending physician. The received by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should sath with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once.	BY PHYSICIAN: MEDICAL CERTIFICATION	23 iM di di re S4 if ca Cci th re P/

	1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF I		MENTAL HYGIEN		
	DOLO (First, Middle, Lest)	M CL	AGG	ETT		2. DATE OF DEATH J	une 13	3. TIME OF DEATH 95 2 06 M
	4. SOCIAL SECURITY NUMBER 579-42-9251	5. SEX 6. AGE	(In yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) July 2, 1		e. BIRTNPLACE (State or Foreign Country) Vest Virginia
<u>«</u>	90. FACILITY NAME (If not institution, give HOLY Cross Hospi				Spring		9c. COUNT	TY OF DEATH
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT		10c. CI	Y, TOWN OR LOCA			Mont	10d. INSIDE CITY
		gomery County	/ Si	lver Spr				1 YES 2 X NO
FUNERAL	8015 Eastern Ave	nue, #210		10	20910			en of what country? ted States
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II	2 NO	if yes, s	CENCENT OF HISPAI	NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)		14. RACE — American Indian, Black, White, etc. Specify: Black
TED	15. DECEDENT'S EDI (Specify only highest grad	JCATION le completed)	(Give kind of	USUAL OCCUPATI	ON ost of working	16b. KIND OF BU	SINESS/INDU	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Waitres	•		Restau	rant	10,00
	17. FATHER'S NAME (First, Middle, Last) Vernell Graves				2.5	ME (First, Middle, Maiden Preston	Sumame)	
TO BE	19e. INFORMANT'S NAME (Type/Print)				and Number or Rural	Route Number, City or Tow		
	Garrick Claggett	206	PLACE AND DATE	OF DISPOSITION /N	eme of			on, DC 20018
	1 Surial 2 Cremation 3 Ren 4 Donation 5 Other (Specify)	F	ort Line			/21/95 Bre	entwoo	d, Maryland
		. Yull	ey	Fort	ND ADORESS OF FA Lincoln Bladenst	Funeral Ho ourg Rd., E	ome, I Brentw	nc. wood, MD 20722
	23. PART i. Enter the diseasea, or ahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cause on DUE TO (OR AS A	de death. Do ch line. Pulut CONSEQUENCE O	not enter the mo	ode of dying, auc	h aa cardlac or raspi	iratory arre	at, Approximate interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A OUE TO (OR AS A	CONSEQUENCE OF	lar A	8 ceiden	l-		Tudday
CERT	resulting in deeth) LAST	of Athero	Schro	to Ju	rare			Year
MEDICAL	PART II, Other significant condition Sevices Sevices	na contributing to death b	ut not reauiting	In the underlyin	g cause given in	Part I. 24s. WAS AN PERFOR	IMINO?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
	DID TOBACCO USE CONT		F DEATH Y		UNCERTAI	N D		
PHYSICIAN:	EXAMINER?	HØSPITAL:		OTHER:	ne 5 🗆 Residenca	6 Cher (Specify)		
	27, NAMES OF BEATS 1 Secure 5 Pending	(Month, Day, Year)	28b. TIN	JURY WO	JURY AT DRK? YES 2 NO	28d, OESCRIBE NOW I	NJURY OCCU	PEO
TED BY	2 Investigation 3 Suicide 8 Could not be 4 Nomicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm,	street, factory, offic	:•	281. LOCATION (Street a City or Town, State)	and Number of	r Rural Route Number,
COMPLETED		BICIAN: To the best of my know ER: On the basis of examination						s. cause(s) and manner as stated.
ш	296. SIGNATURE AND TILE OF CERTIFIE				29c. LUCENSE NUI			SIGNED (Month, Day, Year)
TO B	30. NAME AND ADDRESS OF PERSON WI	HO, COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type	, Print)	11-5	1552	106	21393
	31. DATE FILEO (Month, Day, Year)	M ORD	Greon	Ja Av	e #27	o Silver	LSpn	pha20902
		Les d'audion Ross						



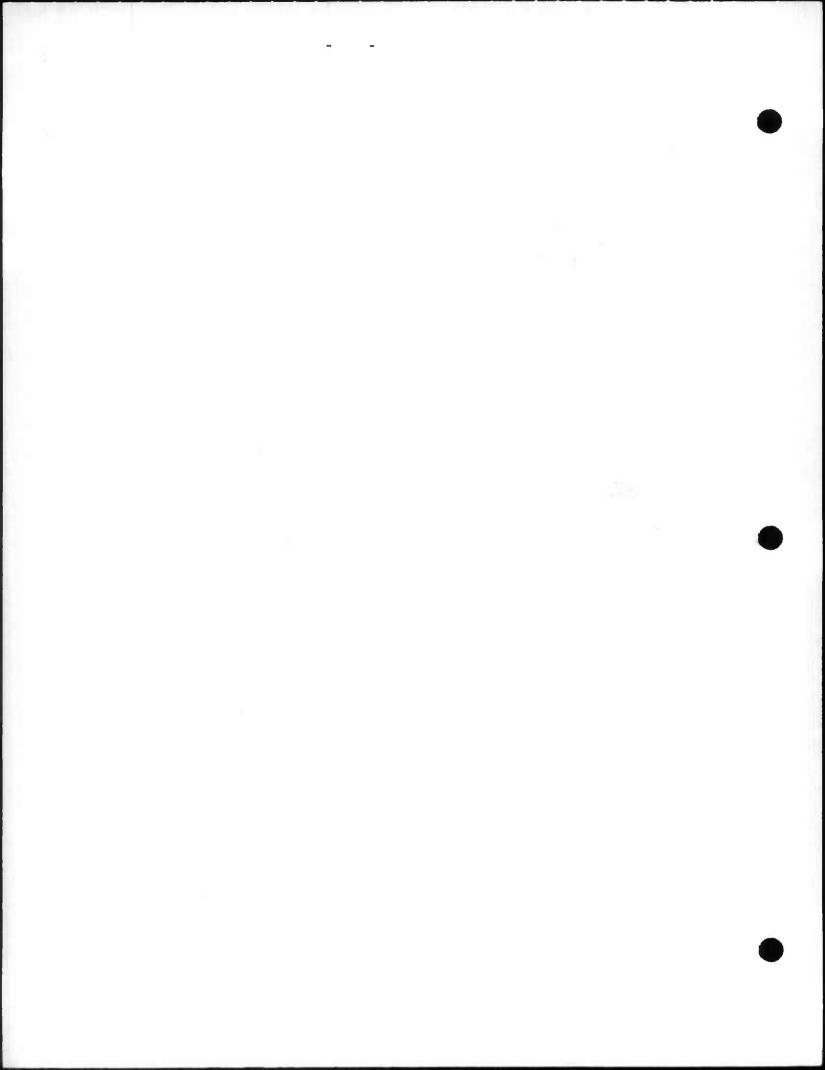
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

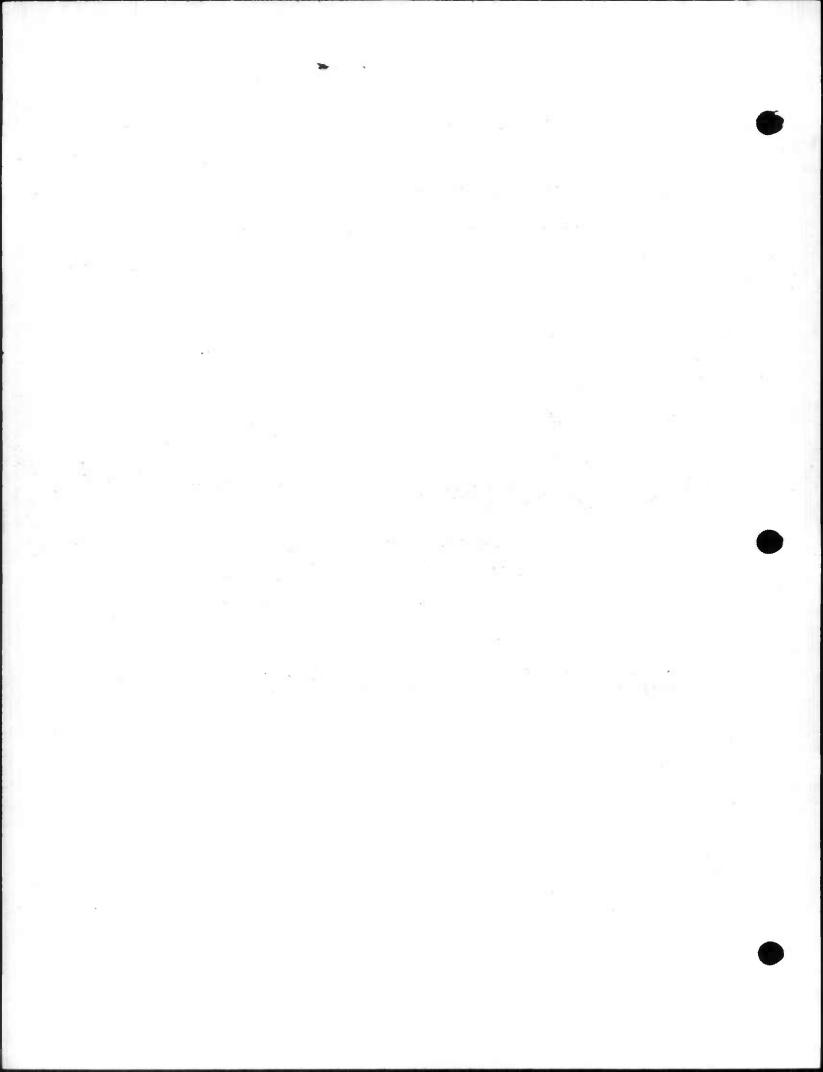
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

	1 - FOR STATE REGISTRAR	TATE OF MARYLANI		ENT OF HEALTH		NTAL HYGIEN	E			
100	1. DECEDENT'S NAME (First, Middle, Last)				2.	DATE OF DEATN	Y YEAF	3. TIME OF DEATH		
		Dennis Cox			June 24 1995			3:55 P: M		
	4. SOCIAL SECURITY NUMBER 5. SI 215-36-3526 1 X	6. AGE (In yrs	: last birthday) IF t	MDER 1 YEAR IF UNDER	9 24 HRS. 7.	DATE OF BIRTH (Month, Day, Year)	B. Bif	TTNPLACE (State or Foreign untry)		
	Se. FACILITY NAME (If not institution, give street and number)			CITY, TOWN OR LOCATION OF DEATN						
DR		Charles County Nursing Home			Plata			9c. COUNTY OF DEATH		
CTC	RESIDENCE OF DECEDENT						Charles			
DIRECTOR	Maryland Charl	es		aldorf				10d. INSIDE CITY LIMITS? 1A YES 2 NO		
AL	10e. STREET AND NUMBER				101. ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?		
NER	3186 Westdale Court			20601			USA			
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried FORCES? 1 YES 2 NO.		(XNO	D 13. WAS DECENDENT OF HISPANIC Of If yes, specify Cuban, Mexican, Pu		RIGIN? (Specify Yee or No— 14. RACE — American Indicented Rican, etc.)				
	3 Widowed 4 Divorced	F YES, GIVE WAR OR DATES		1 TES 2 TNO Specify:			Specify: White			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade comple	N 15a	. DECEDENT'S USU	AL OCCUPATION lone during most of working	na	166. KIND OF BUS	INESS/INOUSTRY	,		
J.E.	Elementary/Secondary (0-12) Coll	llege (1-4 or 5+)	Supervi:	red.)		Food In	dustry			
OME	17. FATHER'S NAME (First, Middle, Last)					First, Middle, Maiden				
BE C	Ira Cox			Eth	el Com	ibs Cox	surreiney			
10 8	19e. INFORMANT'S NAME (Type/Print)	The minima Abbridge (Street and Number of Aural Florida, City of Jown, State, Zip Code)								
	Mary L. Cox			stdale Cou	rt Wal					
	A Donation Comments (Specify)	rom State 20b. PLA	CEAND DATE OF DIS , crematory or other p	emorial Ga	rdons6	OATE 20c. LOC	ATION — City or	Town, State		
	21. SIGNATURE OF FUNDRAL SERVICE LICENSES		00173	22. NAME AND ADDRE	SS OF FACILIT	TY.				
	1 Wy # 75	reen	- 1	J.H. Eber 4433 Whit	wein M e Pls	lortuary La White	Pls. M	D 20695		
	23. PART I Enter the diseases, or complete shock, or heart fallure. List o	ilcations that caused the	daath. Do not e	nter the mode of dy	ing, such aa	cerdiac or respir	retory arrest,	Approximate		
	IMMEMATE CAUSE (Final	17.00		A				Interval Between Onset and Death		
	disease or condition a. COLON CANCER DUE TO (OR AS A CONSCOUENCE OF):									
_	- .	DOE TO (OR AS A COR	ISEOUENCE OF):							
5	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CON	ISEQUENCE OF):							
5	cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR AS A COA	ISEOUENCE OF							
E	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST						1			
CERTIFICATION	1000iting in deatin, Exist									
	d	itributing to death but o	ot requiting in th	a sunderhalme assue	lina la Basa					
	PART il. Other algnificent conditions con	stributing to deeth but no	ot reaulting in th	e underlying cause (given in Part	PERFOR	WED?	4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE		
	d	ntributing to deeth but no	ot reaulting in th	e underlying cause (given in Part		WED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
	d				given in Part	PERFORI	WED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
	DID TOBACCO USE CONTRIBU 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	TE TO CAUSE OF D	EATH YES [NO UNC		PERFORI	WED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
	DID TOBACCO USE CONTRIBU 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 1	TE TO CAUSE OF D 26. P SPITAL: Inpetient 2 ER/Outpetient	EATH YES [LACE OF DEATH (CI	NO UNC	ERTAIN D	PERFORI 1 YES 2	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRIBUTED TO MEDICAL EXAMINER? 1 YES 2 NO 1 OT TOBACCO USE CONTRIBUTED TO MEDICAL EXAMINER? 1 YES 2 NO 1 OT TOBACCO USE CONTRIBUTED TO MEDICAL EXAMINER? 1 YES 2 NO 1 OT TOBACCO USE CONTRIBUTED TO MEDICAL EXAMINER?	TE TO CAUSE OF D	EATH YES [NO UNC	CERTAIN Desidence 6 -	PERFORI	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRIBU 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 1 77. MANNER OF DEATN 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be	TE TO CAUSE OF D 26. P SPITAL: Inpetient 2 ER/Outpetient 26. DATE OF INJURY (Month, Day, Year) 26. PLACE OF INJURY — AI	EATH YES [LACE OF DEATH (CI 3 DOA 4) 28b. TIME OF INJURY	NO UNC neck only one) HER: Nursing Home 5 Re 26c. INJURY AT WORK? 1 YES 2	ERTAIN Desidence 6 = 28d	PERFORI 1 YES 2' Other (Specify) 5. DESCRIBE NOW IN LOCATION (Street at	JURY OCCURED	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRIBU 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 1 27. MANNER OF DEATN 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined	TE TO CAUSE OF D 26. P SPITAL: Inpatient 2 = ER/Outpatient 28e. DATE OF INJURY (Month, Day, Year)	EATH YES [LACE OF DEATH (CI 3 DOA 4) 28b. TIME OF INJURY	NO UNC neck only one) HER: Nursing Home 5 Re 26c. INJURY AT WORK? 1 YES 2	ERTAIN Desidence 6 = 28d	Other (Speally)	JURY OCCURED	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRIBU 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Netural 5 Pending Investigation 1 Accident investigation 3 Sulcide 6 Could not be determined 29e. CERTIFIER (Check only) 1 CERTIFYING PHYSICIAN:	TE TO CAUSE OF D 26. P SPITAL: Inpatient 2 = ER/Outpatient 28e. DATE OF INJURY — A: (Month, Dey, Year) 28e. PLACE OF INJURY — A: butliding, etc. (Specify)	EATH YES LACE OF DEATH (C) 3 DOA 4 29b. TIME OF INJURY t home, farm, street,	NO UNC neck only one) HER: Nursing Home 5 Re 26c. INJURY AT WORK? 1 YES 2 factory, office	Desidence 6 28d NO 28f, end due to the	Other (Specify) 5. LOCATION (Street as City or Town, State)	JURY OCCURED Ind Number or Rura	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
COMPLETED BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRIBU 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Netural 2 Accident 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On MEDICAL INTERPLICATION One) 2 MEDICAL EXAMINER: On MEDICAL INTERPLICATION One)	TE TO CAUSE OF D 26. P SPITAL: Inpetient 2 = ER/Outpetient 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY — Albuilding, etc. (Specify)	EATH YES LACE OF DEATH (C) 3 DOA 4 29b. TIME OF INJURY t home, farm, street,	NO UNC neck only one) HER: Nursing Home 5 Re 26c. INJURY AT WORK? 1 YES 2 factory, office the time, date end place, my opinion, death occur	paldence 6 28d 28d 28d, end due to the red at the time,	Other (Specify) 1. DESCRIBE NOW IN LOCATION (Street at City or Town, State) The cause(s) and manual date and place, and	JURY OCCURED Ind Number or Rura	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
BE COMPLETED BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRIBU 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Netural 5 Pending Investigation 1 Accident investigation 3 Sulcide 6 Could not be determined 29e. CERTIFIER (Check only) 1 CERTIFYING PHYSICIAN:	TE TO CAUSE OF D 26. P SPITAL: Inpatient 2 = ER/Outpatient 28e. DATE OF INJURY — A: (Month, Dey, Year) 28e. PLACE OF INJURY — A: butliding, etc. (Specify)	EATH YES LACE OF DEATH (C) 3 DOA 4 29b. TIME OF INJURY t home, farm, street,	NO UNC neck only one) HER: Nursing Home 5 Re 26c. INJURY AT WORK? 1 YES 2 factory, office	DERTAIN DESCRIPTION OF THE PROPERTY OF THE PRO	Other (Specify) 1. DESCRIBE NOW IN LOCATION (Street at City or Town, State) The cause(s) and manual date and place, and	JURY OCCURED Ind Number or Rura There e stated. Industry the cause 29d. OATE SIGNI	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO No Floure Number,		
COMPLETED BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRIBU 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Netural 2 Accident 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On MEDICAL INTERPLICATION One) 2 MEDICAL EXAMINER: On MEDICAL INTERPLICATION One)	TE TO CAUSE OF D 26. P SPITAL: inpetient 2	EATH YES [LACE OF DEATH (C) 1 3 DOA 4 4 28b. TIME OF INJURY It home, farm, street, death occurred et all o	NO UNC neck only one) HER: Nursing Home 5 Re 26c. INJURY AT WORK? 1 YES 2 factory, office	peldence 6 28d NO 28f, end due to the time, ense NUMBER 064	Other (Specify) 1. DESCRIBE NOW IN LOCATION (Street as City or Town, State) The cause(s) and manifi, date and place, and	JURY OCCURED Ind Number or Rura Ther se stated. If due to the cause 29d. OATE SIGNI	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO No Floute Number, P(e) end manner as stated.		
BE COMPLETED BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRIBU 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 HOST INDUSTRIBU 27. MANNER OF DEATN 1 Netural 5 Pending Investigation 2 Accident investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On 6 29h. BIONATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COM	TE TO CAUSE OF D 26. P SPITAL: Inpetient 2 = ER/Outpatient 28e. DATE OF INJURY (Month, Day, Year) 26e. PLACE OF INJURY — At building, etc. (Specify) To the best of my knowledge the besis of examination end IPLETED CAUSE OF DEATH (I	EATH YES LACE OF DEATH (CI	NO UNC Noteck only one) HER: Nursing Home 5 Re 26c. INJURY AT WORK? 1 YES 2 factory, office the time, date end place my opinion, death occur	peldence 6 28d NO 28f, end due to the time, ense NUMBER 064	Other (Specify) 1. DESCRIBE NOW IN LOCATION (Street as City or Town, State) The cause(s) and manifi, date and place, and	JURY OCCURED Ind Number or Rura Ther se stated. If due to the cause 29d. OATE SIGNI	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO No Floute Number, P(e) end manner as stated.		
BE COMPLETED BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRIBU 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 HOST INDUSTRIBU 27. MANNER OF DEATN 1 Netural 5 Pending Investigation 2 Accident investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On 6 29h. BIONATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COM	TE TO CAUSE OF D 26. P SPITAL: Inpetient 2 = ER/Outpatient 28e. DATE OF INJURY (Month, Day, Year) 26e. PLACE OF INJURY — At building, etc. (Specify) To the best of my knowledge the bests of examination end.	EATH YES LACE OF DEATH (CI	NO UNC neck only one) HER: Nursing Home 5 Re 26c. INJURY AT WORK? 1 YES 2 factory, office	peldence 6 28d NO 28f, end due to the time, ense NUMBER 064	Other (Specify) 1. DESCRIBE NOW IN LOCATION (Street as City or Town, State) The cause(s) and manifi, date and place, and	JURY OCCURED Ind Number or Rura Ther se stated. If due to the cause 29d. OATE SIGNI	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO No Floute Number, P(e) end manner as stated.		



BAL	DSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within E4 hours after death.	INERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funer
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	2	la.
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	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
				2. DATE OF DEATH MONTH JUNE 26.			year 3. TIME OF DEATH A	
Dinc		6. AGE (In yrs. last	YRS. MONTHS DAY	'S HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Dec 18,1	922 W	BIRTHPLACE (State or Foreign Country) Vest Virgini	
CTOR	SOUTHERN MAN	Yland Hospita		N OR LOCATION OF O	EATH	-	NOR GROUP	
FUNERAL DIRECTOR	Maryland Princ	e George's	Suitlan	d			10d. INSIDE CITY LIMITS? 1 YES 2 NO	
FUNERAL	4749 HomerAve			20746		Unit	ed States	
6	11. MARITAL STATUS 1 Never Married Married 3 Wildowed 4 Divorced	FORCES? 1 X YES 2 NO If yes, speci		DECENDENT OF HISPAI , specify Cuben, Mexica YES 2 NO Specif	CENDENT OF HISPANIC ORIGIN? (Specify Yaa or No- ecify Cuben, Mexican, Puerto Rican, etc.) 2 X NO Specify:		14. RACE — American Indian, Black, Whita, etc. Specify: White	
LETED	15. DECEDENT'S EQUCAT (Specify only highest grade col	mpleted) (Gh life.	DEOENT'S USUAL OCCUPA THE kind of work done during Do NOT use retired.)	ATION most of working	16b. KIND OF BI		STRY	
once.	17. FATHER'S NAME (First, Middle, Last)	Grav	vedigger	18. MOTHER'S NA	Cemet			
70	Harry Corbin			Viola		1		
TO BE	19a. INFORMANT'S NAME (Type/Print) Sally A. Corbin	100	MAILING ADDRESS (Stre					
must be	20s. METHOD OF DISPOSITION 1X Buriel 2 Cremetion 3 Remove 4 Donation 8 Other (Specify)	20b. PLACE A	1749 Home ND DATE OF CISPOSITION Detory or other place) Land Vete	(Name Trino 2	Q plot Q Gene I	ocation - cit elten	y or Town, State ham, Maryla	
examiner	21. BIGHATURE OF FUNERAL SERVICE LICEN		22. NAME	AND ADDRESS OF FA	currLee Fu	neral	Home, Inc66	
medical	23. PART I. Enter the distance, or com- shock, or flear failure. Lie IMMEDIATE CAUSE (Finel	nplications that caused the decit only ona cause on each line.						
rent, the	disease or condition resulting in death)	SEVERE ISCHEMIC CARDIOMYOPATHY				MONTHS.		
. 6		DUE TO (OR AS A CONSEQUENCE OF): INTRACTABLE CONGESTIVE HEART FAILURE				Weeks		
traumatic e	Sequentially liet conditions, if any, leading to immediata ceuse. Enter UNDERLYING	DUE TO (OR AS A CONSEQUENCE OF): Prob.Myelopæoliferative disorders				Months		
ijury, or other traumatic L CERTIFICATION	CAUSE (Disease or Injury that Initiated evente resulting in death) LAST d. Pancytopenia				months.			
를	refractory anem	ontributing to death but not resulting in the underlying cause given nia ,leucopenia,thrombocytope ollagen vascular disease		ocytoper	Part I. 24a. WAS AI PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?	
n 23 shows any	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN						1 TYES 2 NO	
with the State Dept. or realth at ted, or Item 23 shows any PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 N NO 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Normaliant 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)							
	27. MANNER OF DEATH 1	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF 28c.	INJURY AT WORK? YES 2 NO	28d. DESCRIBE HOW	JURY OCCURED		
	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide detarmined	28a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify)		281. LOCATION (Street and Number or Rural Route Nur City or Town, State)		Rural Route Number,		
TANT: It tem 28 Is COMPLETED		IN: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(a) and menner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(a) and manner as stated.						
PORTANT: BE COI	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)		
10	30, NAME AND ADDRESS OF PERSON WHO C	OMOTE ED CAUSE OF PEACH	27 (500 0000	D 128	384	June	26 1995	
	PETER W.YIM M.D. 7900 OLD BRANCH AVE. SUITE 101, CLINTON, MARY							
	31. DATE FILED JUN 2 8 1995	32. REGISTRAN'S SIGNATURE	ardall					



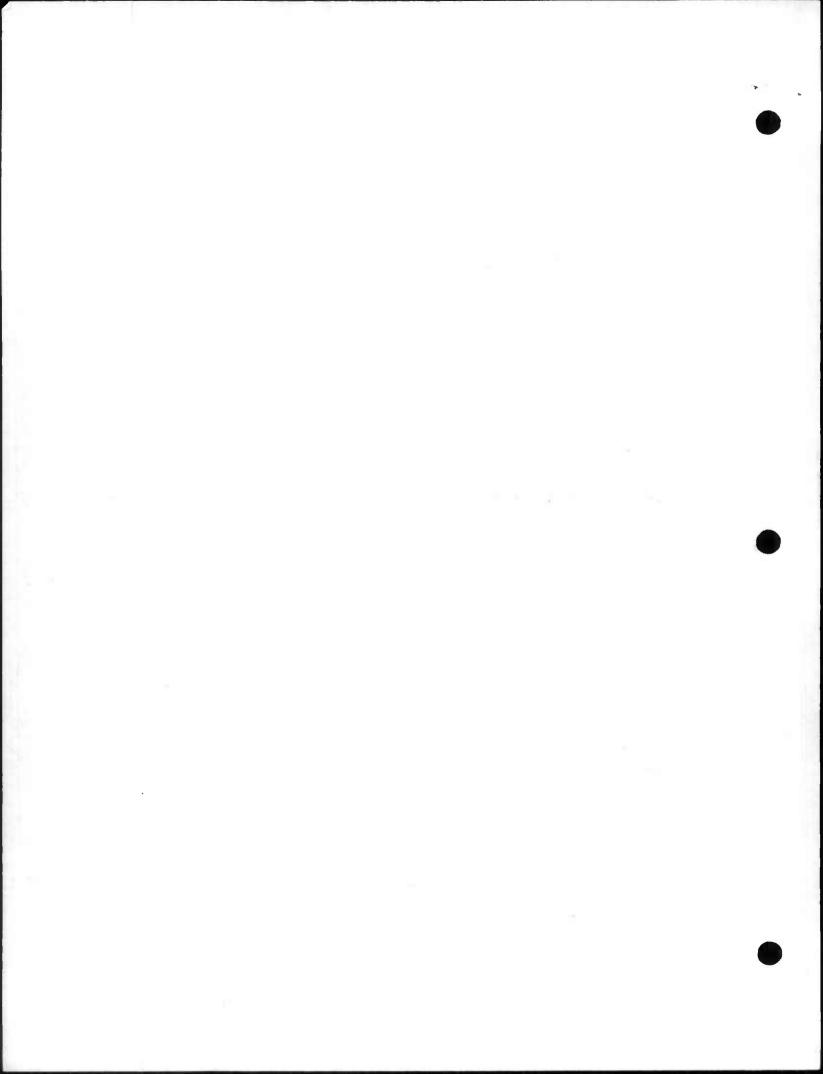
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 55 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR

	REGISTRAR	CERTIFI	CATE C	F DEATH	REG. NO						
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH				
	Charles Gordon Clews				June 23	1995	7:12 P M				
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In vrs. last birthday) FUNDER 1 YEAR FUNDER 24 MRS 7 DATE OF BURTH 9 BUR										
	$316-30-9375$ 1 X M 2 \square F 81 YRS. MONTHS DAYS HOURS MIN. May 2 bed 914 Ma										
	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DE										
DIRECTOR	Northwest Hospital Center Randallstown Baltimo										
E I	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION										
<u>ā</u>	Maryland Carroll	We	estmi	nster			10d. INSIDE CITY LIMITS? Y YES 2 NO				
	10e. STREET AND NUMBER			10f. ZIP CODE		N OF WHAT COUNTRY?					
FUNERAL	205 St. Mark Way, Apt. 425			21158		United					
٦	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S 1 Never Married 2757/Married FORCES? 1 YES 2	ARMED	13. WAS	DECENDENT OF HISPA	VIC ORIGIN? (Specify Yes	or No- 1	4. RACE — American Indian, Black, White, elc.				
ВУ	1 Never Married 2 Married FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES			YES 2 XNO Specif			Specify: White				
	15. DECEDENT'S EDUCATION 16a	. DECEDENT'S	USUAL OCCUP	PATION	16b. KIND OF BU	SINESS/INDU					
E	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	(Give kind of w life. Do NOT use	ork done during	most of working							
립		Minist	er		Church	1					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NA	ME (First, Middle, Meiden						
BEC	William Clews			Fanni	9	Will	iams				
0 8	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING	ADDRESS (Str	eet and Number or Rural	Route Number, City or Tow						
F	Eleanora Marie Clews	205 \$	St. M	ark Way,	Apt. 425	, We	stminster, MD				
	20a. METHOD OF DISPOSITION 1 Seurial 2 Cremellon 3 Removal from State 20b. PLA	CEAND DATEO	F DISPOSITIO	N(Name of /28/	95 DATE 20c. LO	CATION — CH	ly or Town, State				
				emeterv			burg, MD				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	_	22. NAM	E AND ADDRESS OF FA	CILITY						
3	Katherine Pritts - Sweitsel				eral Home		napel tminster, MD				
	23. PART I. Enter the diseases, or complications that caused the	death. Do n	ot enter the	mode of dving, aug	h as cardiac or reap	ratory arres	it, Approximate				
	anock, or neart failure. List only one cause on each	line.		,			Interval Between Onset and Death				
	iMMEDIATE CAUSE (Fine) disease or condition resulting in death) a. SEPTICEMIA GRAM D BACTERIA DUE TO (OR AS A CONSEQUENCE OF):										
	DUE TO (OR AS A CON	NSEQUENCE OF): (070	114(7) 3	TUEKIA	/	7877761				
z	ABADMINAL WOUND										
임	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE, (Disease or Injury. CAUCINOMA SITE UNDETER MINEN - INTESTINAL?										
SA	CAUSE (Disease or Injury	OMA.	SITE	UNDET	ER MINEN	-INTE	77NAL?				
H	that initiated events DUE TO (OR AS A CON resulting in death) LAST	SEQUENCE OF):	,							
DICAL CERTIFICATION	d.										
١٢	PART II. Other aignificant conditions contributing to death but no	ot reaulting is	the underl	ying cause given in	Part I. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS				
2		ATTW			PERFOR		AMAILABLE PRIOR TO COMPLETION OF CAUSE				
MED					1 YE\$ 2	- NO	OF DEATH?				
≥	DID TOBACCO USE CONTRIBUTE TO CAUSE OF D	EATH YE	SUNO	LINCEPTAL			1 Tes 2 No				
NA.		LACE OF DEAT			10						
PHYSICIAN:	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Pinpetient 2 ER/Oulpetien	4 3 DOA	OTHER:	Home 5 🗆 Realdenca	# C 00 10 11						
Ë	27. MANNER OF CEATH 28s. DATE OF INJURY	28b. TIME	OF 28c.	INJURY AT	28d. OEŞCRIBE HOW I	NJURY OCCU	RED				
	1 Natural 5 Pending (Month, Day, Year)	INJU	JRY	WORK?							
BÁ	3 Suicide 28e. PLACE OF INJURY — A	it home, larm, st			281. LOCATION (Street a	and Number or	Rural Route Number				
밀	4 Homicide detarmined building, stc. (Specify)				City or Town, State)						
١٣	29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge	death occurre	d at the time	data and place, and due	In the country and and						
COMPLET	(Check only one) 2 MEDICAL EXAMINER: On the basis of examination and										
	29b, SIGNATURE AND TITLE OF CERTIFIER	1.1		- T							
#	William Int.	16		A 2 G /)		SIGNED (Morth, Dey, Year)				
유	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ((ITEM 27) (Type	Print)	0/3//	,		13,/79				
	COSO FALLS ROAD / BA			MA 21	2-06						
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATUR	(0)/10/	3/60 /		ru7.	_					
- 1	JUN 2 7 1005 (4): Asimi. P. A.				-						



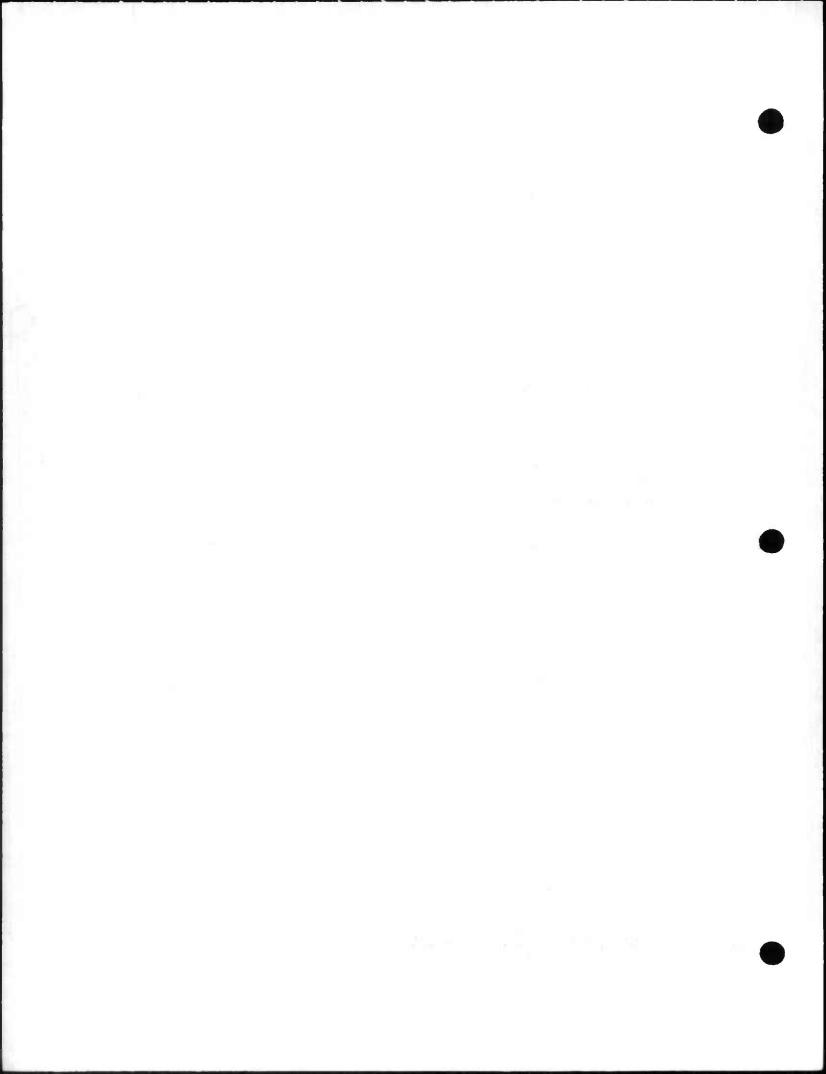
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 54 hours after death. Page 6 may be retained by the hospital or attending physician. In THE STINERAL DIRECTIONS, they this certificate has been alread by the attending physician and completely filled in his the second discourse.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1	1. OECEDENT'S NAME (First	Middle Last)								2. DATE OF DEA	-		
		BRUCE		ERNON	DIC	CKIN	SON				MONTH	DAY	YEAR	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER		5. SEX	_							10, 19		0700 M
		100		1797		n yrs. last l	MO	WITHS DA	AR IF U	NDER 24 HRS.	7. DATE OF BIR' (Month, Day,)	harl	8. BIRTHPLACE (State or Country)	
	_									February	25, 190	5 Vi	rginia	
		9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH											DEATH	
	CTOR	512 Pine Bluff Rd. Salisbury Wicomico												0.0
	<u>ដ</u>	RESIDENCE OF DEC	10b. COUNT	,		Т	10c. CITY, T	OWN! OD !	OBATION:					
	DIRE	Maryland Wicomico Salisbury												10d. INSIDE CITY LIMITS?
		10e. STREET AND NUMBER		Omiteo			Ja.	TISDU						1 YES 2 NO
	RAL	512 Pine		DJ					10f. ZiP (10g. (WHAT COUNTRY?
	FUNER	11. MARITAL STATUS	DIUII							801			USA	1
	문	1 Never Married 2	Merried	12. WAS DECEDEN FORCES? 1							NC ORIGIN? (Spec		- 14. RAC Blac	E — American Indian, ck, White, etc.
	B	3XXWidowed 4 Divo		IF YES, GIVE V	MAR OR DAT	TES				NO Specify			Spec	elly:
	ED	15 DEC	EDENT'S EDU	CATION		44- 0500								nite
	1	(Specify only	y highest grade	completed)		(G/ve	EDENT'S USU kind of work Oo NOT use re	done durin	g most of w	orking	16b. KIND (F BUSINESS/	INDUSTRY	
	COMPLET	Elementary/Secondary (0	1-12)	College (1-4 or 5	+)						۰			
Ce	ME	17. FATHER'S NAME (First, M	. 4 4			COUR	mercia	al Ar				ertisi		
at once.			- CV C.	1. 1. 1					18. N		ME (First, Middle, A	_		
a a	띪	Harry L	_	oickinson	<u> </u>					Hatti		Godw		
notified	0	19e. INFORMANT'S NAME (7)									Route Number, City			
pe n		Mary Loui		lott		4(05 Pir	ne Bl	uff !	Rd., S	Salisbur	y, MD	2180	
must b		20a. METHOD OF DISPOSITI 1 1 Burlet 2 ☐ Cremetion	ION on 3 🗆 Flaims	ovel from State			DO DATE OF D		N (Name of		DATE 2	c. LOCATION	— City or To	own, State
nous aret dean with the Cale Dept. of realin and Mema Hygere prof to burial, cremation, of remova. Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.		4 Donation 5 Other	(Specify)	/	W	icom:	ico Me	emori	al P	ark	6/13	Salis	bury,	MD
ine		21. SIGNATURE OF FUNERA	L BEHYICK LIC	ENGER						DRESS OF FA				
хэш		1/1/16	1/1	///		/)				neral Ho			
cai	_	23. PART I. Enter the di				-	/_	50	I Sn	ow Hil	1 Rd.,	Salist	ury,	MD 21801
9	0.0	shock, or he	eart failurs.	List only one cau	ate an ear	ch line.	iii. Do not	ciliai die	mode of	dying, suci	n ss cardiec or	reepiratory	srrest,	Approximats Interval Between
e e		IMMEDIATE CAUSE (Fin	ial	1		,		D	()		_			Onset and Death
-		disease or condition resulting in death)	→ ,	.HRTERI	05c1	ero.	tre (ard	iovo	uscul	ar Dis	ease		Years
ever		disease or condition resulting in death) a. ARTERIOSCIENOTIC Cardiovascular Disease Years DUE TO (OR AS A CONSEQUENCE OF):												
2	Z	Sequentially list conditions, b												
E	월	if sny, lesding to immed	diate	DUE TO	(OR AS A C	CONSEOU	ENCE OF):							
1	CERTIFICATION	CAUSE (Disease or Inju		n.										
1	#	that initiated events		DUE TO	(OR AS A C	CONSEQU	ENCE OF):							
6	#	resulting in death) LAS	' L.	s										
in'y		PART II. Other eignifice	nt condition	s contributing to	death hu	t not rec	willian in th	ho under	ulas sau		Dest la		. II	
ows any injury,	MEDICAL	Diabetes			Geatti bu						Part I. 24e. W	AS AN AUTOPS RFORMED?	246	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
2 3	ă	17 Luijeres	<u>v.1611</u>	1145							1 🗆 Y	ES 2 KNO		COMPLETION OF CAUSE OF DEATH?
how	_													1 TES 2 NO
23 8	ä	DID TOBACCO U	SE CONTE	RIBUTE TO CA	USE OF	DEATH	H YES		☐ UI	NCERTAIN	1 🗆			
E	5	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26	6. PLACE	OF DEATH (one)					
11	PHYSICIAN:	1 - YES 2 NO		1 Inpetient 2	ER/Output	tient 3 🗆	DOA 4	THER: Nursing	Home 5 🎘	Residence	6 Other (Specify	1)		
ď,	포	27. MANNER OF DEATH		28a. OATE OF (Month, D		:	28b, TIME OF		INJURY AT		28d. DEŞCRIBE I	IOW INJURY	CCURED	
Jark	ВУ		Pending restigation	(Monin, D	-,,/		Moon		YES	2 🗌 NO				
10		3 Sudalda	Could not be	28e. PLACE O	F INJURY -	At home	o, farm, stree	t, factory,	office		26f. LOCATION (S	treet end Num	ber or Rural I	Route Number,
28	W		Setermined	bunding,	etc. (Specif)	y)					City or Town,	State)	and the same	
E	W	29e. CERTIFIER	EVINO BUNDO		i e a reas	N. Tarana			-1 -11			SHIP S	III.S	
=	₩ I			CIAN: To the best of										The second second
MPORTANT: IL	COMPLET				AUTHINETION (end/of Inv	eangation, ir	ny opinic	n, death oc	cured at the	time, date and pla	ce, end due to	the ceuse(s	e) end menner ea stated.
ORT	ш	296. SIGNATURE AND TITLE	OF CERTIFIER		1.		0,		29c. l	LICENSE NUM	-	29d. D	ATE SIGNED	(Month, Day, Year)
F	TO B	Juanas (Nell	AMU	HHen	d ing		51216	1	0080	108		6-12	2-95
	F	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	SE OF DEAT	TH (ITEM 2	27) (Type, Prin	nt)					, ,	
		108 Pine	13/4/	L'Road.	SC	alis	DUR	MAL	1 21	801 -	1 Hom A	SC,	Hill	JRM.D
- 1		31. DATE FILED (Month, Day,)	_	32 REGISTRA	R'S SIGNAT	TURE		1					/	
/		JUN 1	3 1995	Julia att	ivalian	Rando	M	*						
L														

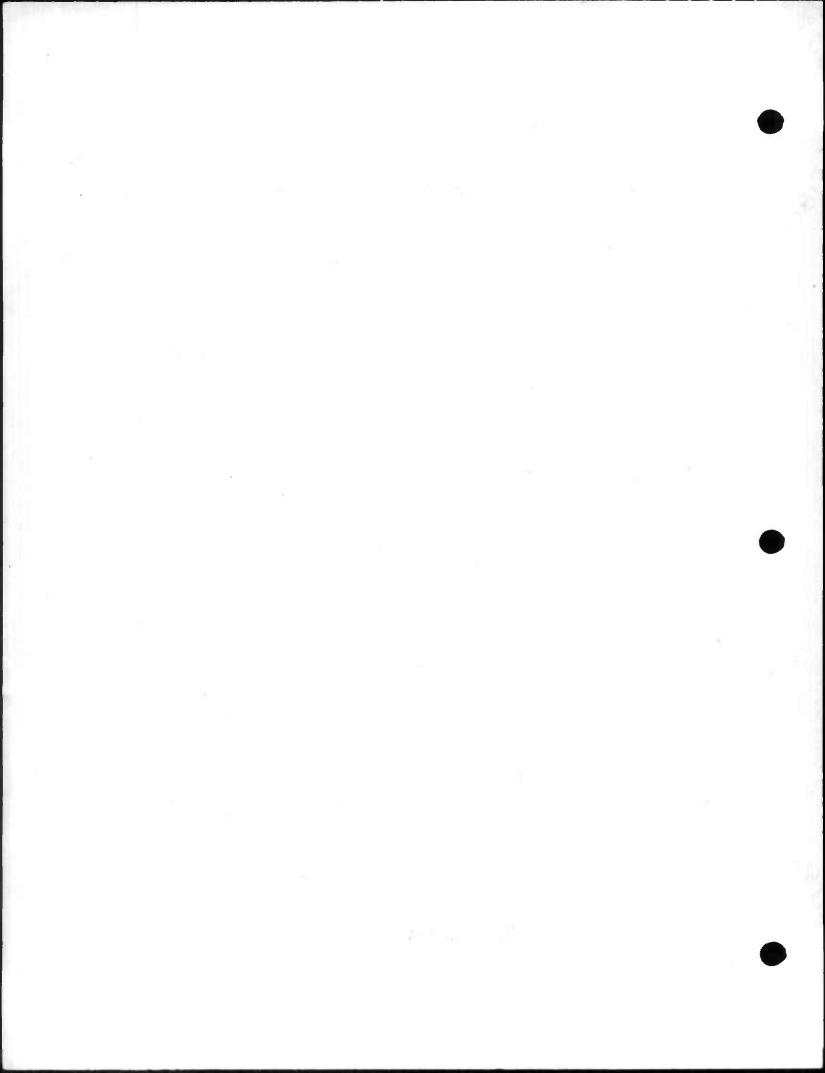


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

) THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician	s the bunal-tra	filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
spital or atter	hed for use a		
ed by the ho	uld be detact		and and assess
may be retain	r, page 5 sho		PORTANT If item 28 is marked or item 23 shows any Injury or other trainmails over the medical examines must be notified at ourse
ath. Page 6	meral directo		amine me
nours after de	d in by the fu	or removal.	madical av
d within 24 I	ompletely fille	I, cremation,	ovent the
ite be execute	ysician and c	prior to buria	fraumatic
leath certifica	attending ph	rital Hygiene	or other
es that the d	gned by the	salth and Me	e any Inim
he law requir	s has been si	e Dept. of He	m 23 chow
PHYSICIAN: 1	this certificat	with the Star	rked or its
ATTENDING	CTDR: After	s after death	28 is mai
SPITAL OR	INERAL DIRE	thin 72 hours	NT- If item
포	THE FU	filed wit	IPORTA

		FOR 1 - STATE REGISTRAR		STATE OF	MARYLAN		RTMENT (MENTAL HYGIE			
		1. DECEDENT'S NAME (First	, Middle, Last)			<u> </u>	TOATE		DEA		2. DATE OF DEATH	0.		3. TIME OF DEATN
		PAULINE		EVANS		עם	RBY				MONTH	3 1	YEAR	
		4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In v	rs. last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.				7. DATE OF BIRTH	. 3 1		10:56 PM
		214-32-624	2	1 - M 2 2 F	12 12 F 58 YRS. M			AYS	HOURS	MIN.	(Month, Day, Year)		Count	try)
pino		9a. FACILITY NAME (If not in		reet and number)			9b. CITY, TO	NAN 0	B L OCATIO	W OF DE	April 28,		UNTY OF I	orth Carolin
3 should	<u>m</u>				OCDIM	2.5					ain			
1, 2,	DIRECTOR	PENINSULA	EDENT	ONAL H	JSPIT	AL	I SA	나	SBUI	Υ Υ		W	ICO	MICO
Sec	JE .	10a. STATE	10b. COUNTY	,		10c. Cl	TY, TOWN OR L	OCAT	ION					10d. INSIDE CITY
£:	ō	Maryland	Wico	mico			Delman							LIMITS?
Derm	AL	10a. STREET AND NUMBER		10f. ZIP CODE 10g. CITIZEN OF WHAT COL										
for use as the bunal-transit permit. Pages	FUNERAL	Melson Rd. 21875 USA									1			
al-tra	5	11. MARITAL STATUS		12. WAS DECEDEN			13. WAS	DEC	ENDENT O	F HISPAN	IC ORIGIN? (Specify	tes or No	14. RAC	E American Indian,
Dig a	BY F	1 Never Married 2 3 Never Married 2 1 Never Married 2 Never Ma		FORCES? 1					cify Cubar 2 X NO		, Puerto Rican, etc.)		Spec	k, White, atc.
as th											Whi			
use	ЕТЕР	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use relating.) 16b. KIND OF								16b. KIND OF E	USINESS/IN	DUSTRY		
D for	١٣١	Elementary/Secondary (0	L-12)	College (1-4 or 5	Conege (1-4 or 5+)									
detached once.	COMPL	10 Seamstress Clothing Manufacturer										cturer		
at o	-	William D	, ,	Duffie				- 1			ME (First, Middle, Maid ouise Co	,		
	H			Durite		401 444 11								
5 should notified	임	19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
De d		MA METHOD OF DISPOSITION												
ector, p		1 Burial 2 Cremation 4 Donation 6 Other	n 3 🗆 Remo	ryel from State	cemeter	y, cremetory or	other place)							
dire.		21. SIGNATURE OF FUNERAL		ENSEE	<u> </u>	alisbui	y Cren		OTY D ADDRES	C OF SAC		alist	ury,	MD
the funeral director, page wal.		111/2	///	11	0	_					neral Hon	ne		
wal.		MIC	· / Ya	Clons	<u> </u>		5	501	Snor	w Hi	11 Rd., S	alist	oury,	MD 21801
remo		23. PART I. Enter the di ahock, or he	seases, or c	omplications the	t coused th	a death. Do	not enter the	mod	de of dyir	ng, auch	as cerdlec or res	piretory ar	reet,	Approximate
n and completely filled in by the to burial, cremation, or removal imatic event, the medical		IMMEDIATE CAUSE (Fin		,	7./		1 .	•	1 4=					Onset and Death
matio		disease or condition resulting in death) •. Plad + Munics												
d, cre				DUE TO	(OR AS A CO	NSEQUENCE C	NF):		1					
y the attending physician and co d Mental Hygiene prior to buria Injury, or other traumatic	8	Sequentially list conditi	ons.										•	
sician and c infor to buriz traumatic	FICATION	if any, leeding to immed ceuse. Enter UNDERLY	dieta	DUE TO	(OR AS A CO	NSEOUENCE C	F):							
physic le pri	일	CAUSE (Disease or inju		DUE TO	(OR AS A CO	NSEQUENCE C	Ф.							
ding lygier	RT	that initiated events resulting in death) LAS	т	DOE 10	(OH AS A CO	MSEQUENCE C	rj:							i
atten ntal +	Ü	d												
y the	_ [PART II. Other algnifica	nt conditions	contributing to	deeth but r	not resulting	In the under	lying	cause g	lvan in I			24b	. WERE AUTOPSY FINDINGS
ith an	OICA										M	2 NO		AVAILABLE PRIOR TO COMPLETION OF CAUSE
of Heal	MEDI										_ \\			OF DEATH? 1 YES 2 □ NO
beer of sh		DID TOBACCO U	SE CONTR	IBUTE TO CA	USE OF D	DEATH Y	ES 🗆 NO		UNC	ERTAIN				
e has b e Dept. m 23	PHYSICIAN:	25. WAS CASE REFERRED TO					TN (Check only							
or Item	SIC	EXAMINER? 1 XYES 2 NO		HOSPITAL:	YER/Outpatia	nt 3 🗆 DOA	OTHER:	Nome	5 🗆 Res	Idence	Dther (Specify)			
th th	둦	27. MANNER OF DEATH		28a. DATE OF	-	26b. Til	E OF 28d	. INJU	JRY AT		284 RESCRIBE HOW	INJURY OG	CURED	4
fter this c sath with marked,	ВУ		Pending nvestigation	6/13	195	22	20 M	WOF	IV.	NO	UTive	r in	and	bacident
R. Aft	ED E	3 Suicide 8	Could not be	28e. PLACE O	F INJURY - /	At home, term,	street, tectory,	office			281. LOCATION (Street	and Numbe	r or Rural I	Poute Number,
s afte		4 Nomicide	determined			21/2	GET				PUTS VI	lle -	-mey	SON RD
DIRE hours	PLE	29a. CERTIFIER 1 CERT	IFYING PHYSIC	IAN: To the best of	my knowledg	a, death occur	ed at the time,	data a	and place,	and due t	o the cause(a) and m	anner as ata	ited.	
FRAL	СОМ													s) and manner as stated,
With		20 AGHATURE AND TITLE						_	29c. LICER					(Month, Day, Year)
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the filed within 72 hours after death with the State Dept. of Health and IMPORTANT: If Hem 28 is marked, or Item 23 shows any It	BE	Clan	_ (uken	ND					C.M			JUNE	
F & S	2	30. NAME AND ADDRESS OF	PERSON WNO	COMPLETED CAUS	SE OF DEATN	(ITEM 27) (Type	, Print)	_				1	OLYL	741777
ļ		JUARON	600	KE, M				ee	et,	Bal	timore,	Mary	/lan	d 21201
Ī		31. DATE FILED (Month, Day,	(bar)	32 AGGISTER					_					
6		JUN 1	5 1995	Julia do	ANGROS!	THE PERSON NAMED IN								

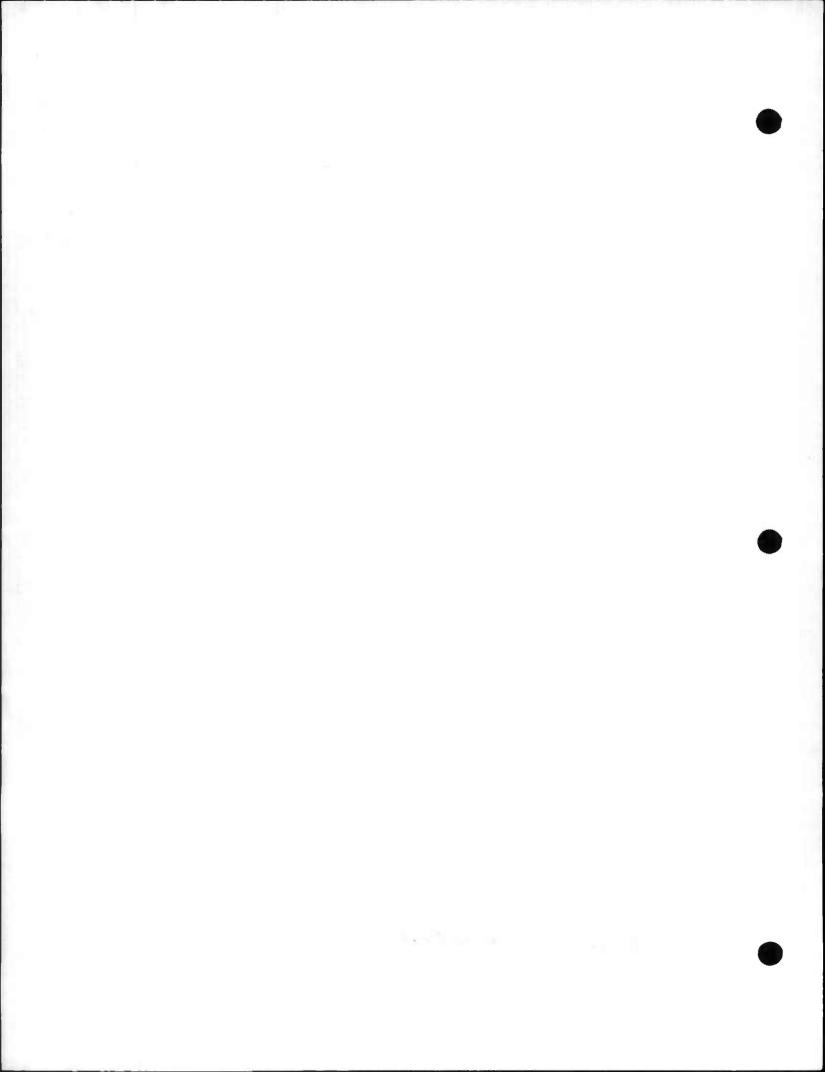


BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	e executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. In and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should to burial, cremation, or removal.	er traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF HE	ALTH AND	MENTAL HYGIEN	E							
	1. DECEDENT'S NAME (First, Middle, Last)	11.0		MIELL		2. DATE OF DEATH MONTH D.	Y YEA	3. TIME OF DEATH						
	4. SOCIAL SECURITY NUMBER	1			IF UNDER 24 HRS.	7. DATE OF BIRTH		RTHPLACE (State or Foreign						
	219-62-8806	1 [] x 2 [] F	40 YRS. "		HOURS MIN.	(Month, Day, Year)	354 M	ARY/AND						
œ	9a. FACILITY NAME (If not institution, give stree		- 1	b. CITY, TOWN OR			9c. COUNTY O	F DEATH						
20	PENINSULA REGIONAL	MEDICAL CEI	NTER	SALIS	BURY		WICO	MICO						
DIRECTOR	Maryland Wico	N ₁ CO	10c. CITY,	TOWN OR LOCATIO	ON COLUMN			10d. INSIDE CITY LIMITS?						
	10e. STREET AND NUMBER	1		115 DU F	TIP CODE		10g. CITIZEN C	1 YES 2 NO						
FUNERAL	1114 Kenosk				21801		US	SA						
	1 Never Married 2 Narried	FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO		ify Cultan, Maxica	NIC ORIGIN? (Specify Yea in, Puerto Rican, etc.)	8	ACE — American Indian, lack, Whita, etc.						
D BY	3 Widowed 4 Divorced 15. DECEDENT'S EDUCAT	1975-1	981				IAH	rICAN AMERICAN						
COMPLETED	(Specify only highest grade co.		16a. DECEDENT'S U: (Give kind of wo	rk done during most		16b. KIND OF BUS	INESS/INDUSTR	Y						
MPL	12th grade		labor	er			ding							
	17. FATHER'S NAME (First, Middle, Last)	Dashiell,	TR.		18. MOTHER'S NA	ME (First, Middle, Melden	Sumame							
TO BE	19a. INFORMANT'S NAME (Type/Print)	zusinch,		DDRESS (Street and	Number or Rural	Route Humber, City or Tow	, State, Zip Code,	C						
	Charlene Doshiel	<u> </u>	1401 D	rsey L	one-S	alisbury	, MD	21801						
	1 Buriel 2 Cremation 3 Remove 4 Donation 5 Other (Specify)		PLACE AND DATE OF netery, cremetony or other ICAN Ship		meteril	6/18 AL	CATION - City of	ARVAND						
	21. SIGHATURE OF FUNERAL SERVICE LICEH	ISEE	C Lasp	22. HAME AND	ADDRESS OF FA	CILITY 1213 J	ersevi	Road 21801						
	+ alreur	a Stille	Н	Jolley	Memo	nal Chape	15-5	alisbury MD						
	23. PART i. Enter the diseases, pr con shock, pr heert fallure. Lis	nplications that ceuse at only one ceuse on e	the deeth. Do not ch line.	enter the mode	of dying, suc	h es cerdiec or lespi	ratory arrest,	Approximete interval Between						
	iMMEDIATE CAUSE (Finel disease or condition	O. ffuco	10000	611	_	4		Onset and Death						
	resulting in death) a	O. Hose	CONSEQUENCE OF):	0	in my	00,44								
<u>S</u>	Sequentially list conditions,	DUE TO (OR AS A	CONSEQUENCE OF):											
3	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury							İ						
RTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):											
	PART II. Other significent conditions	contributing to death h	ut not resulting in	the underlying	reuse alven in	Bord t Oc. Mag au	ALITTOPIO V							
ZA		- To does to	ot not resulting in	the underlying t	zause given in	Part I. 24a. WAS AH PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE						
MEDIC						_		OF DEATH?						
AN	DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL	BUTE TO CAUSE O	F DEATH YES	-	UNCERTAI	N 🗆								
PHYSICIAN:	EXAMIHER?	OSPITAL:		THER:	5 Rasidence	8 Other (Specify)								
F.	27. MAHHER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME (OF 28c. IHJUR	TY AT	28d. DESCRIBE HOW II	JURY OCCURED							
à	2 Accident Investigation	28s. PLACE OF IHJURY	— At home ferm etr		S 2 NO	201 LOCATION (Creat	ad Humber or Bu	- Contraction						
	1 Quiolde	28e. PLACE OF IHJURY — At home, farm, atrast, factory, offica building, etc. (Specify)				281. LOCATIOH (Street and Humber or Rural Route Humber, City or Town, State)								
	3 Suicide 6 Could not be 4 Homicide determined		29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAH: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated.											
APLEIED	4 Homicide determined 29a. CERTIFIER (Check only	H: To the beat of my know												
COMPLEIED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:	H: To the beat of my know		In my opinion, dear	th occured at the	time, data and place, an	due to the caus							
BE COMPLE	4 Homicide determined 29a. CERTIFIER (Check only	H: To the beat of my know		In my opinion, dear	th occured at the	time, data and place, an	due to the cause	IED (Month, Day, Year)						
IO BE COMPLETED	29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIER 30. HAME AND ADDRESS OF PERSON WHO CO	On the best of my know	n and/or investigation, ATH (ITEM 27) (Type, Pr	In my opinion, dear	th occured at the	time, data and place, an	29d. DATE SIGN	IED (Month, Day, Year)						
BE COMPLE	29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIER 30. HAME AND ADDRESS OF PERSON WHO CO	On the beat of my know On the beale of exemination	ATH (ITEM 27) (Type, Pr	In my opinion, dear	th occured at the	time, data and place, an	29d. DATE SIGN	IED (Month, Day, Year)						



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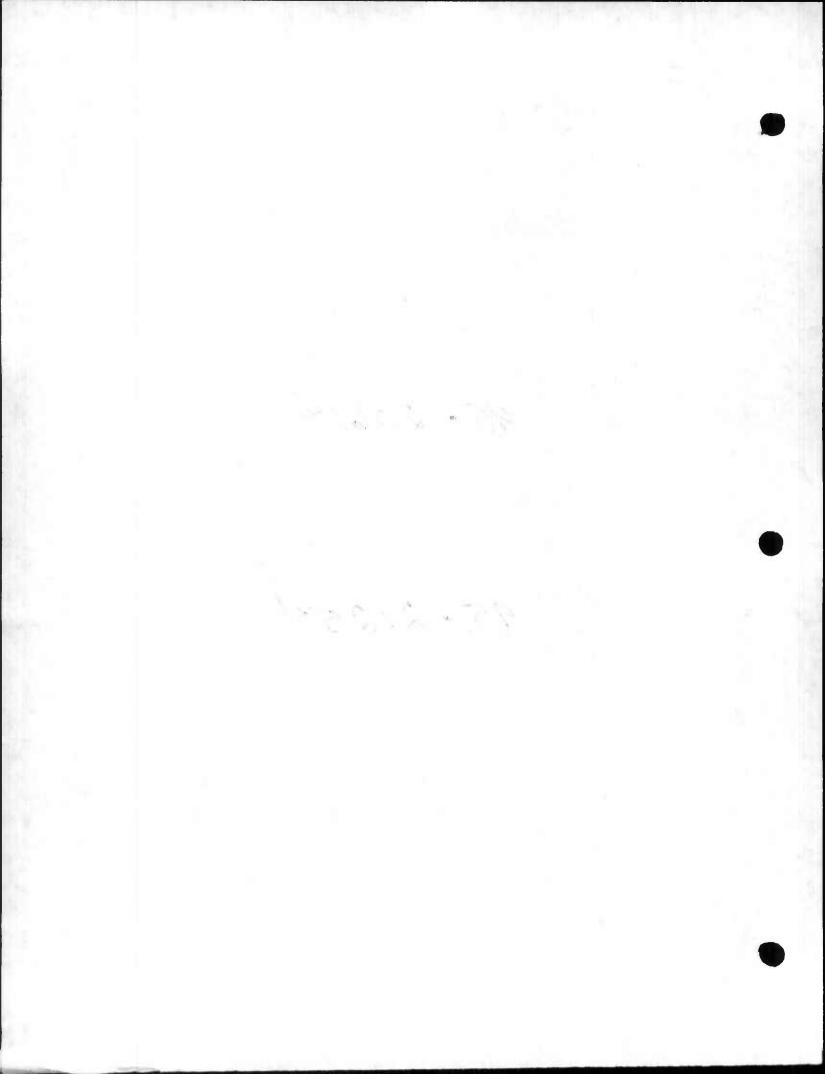
STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH NHOL THOMAS DELL Jun 28 1995 9:29 am 4. SOCIAL SECURITY NUMBER 5 SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign Feb. 20, 1908 212-10-9814 1 X M 2 - F 87 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street 9b. CITY, TOWN OR LOCATION OF DEATN 9c, COUNTY OF DEATH Saint Joseph Medical Center DIRECTOR Towson, Maryland Baltimore RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Parkton 1 YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Page 6 may be retained by the hospital or attending physician. al director, page 5 should be detached for use as the burial-transit 547 Bentley Road 21120 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2X NO Specify: Specify: BY 3 Widowed 4 Divorced White 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high funeral director, page 5 should be detached for College (1-4 or 6 +) COMPL 8 Machinist Tool Mfg. once. 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname Nimrod Q. Dell notified at Anna M. Frev 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 M. Beatrice Dell 547 Bentley Rd., Parkton, MD 21120 must be 20a METHOD OF DISPOSITION
1 🔯 Burlel 2 🗆 Cremation 3 🗆 Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State July 1, Mt. Zion Cemetery 4 Donation 5 Other (Specify) Freeland, the medical examiner 21. SHONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY after death. J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 Xar. ysician and completely filled in by the prior to burial, cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the desth. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Pours Interval Betw IMMEDIATE CAUSE (Final Onset and Death ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) 1 DAY event, DUE TO (OR AS A CONSEQUENCE OF) CORONARY ARTERY DISEASE YEARS traumatic CERTIFICATION Sequentially list conditions, DUE TO JOR AS A CONSEQUENCE OF) If sny, lasding to immediate the attending physician I Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 9 injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO n signed by the Health and M shows any COMPLETION OF CAUSE 1 TYES T OF DEATH? 1 YES 2 NO has been s Dept. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) this certificate h with the State I 1 YES 2 NO HOSPITAL: OTHER: SPITAL: X
Inpellant 2 ER/Outpetlent 3 DOA DR ATTENDING PHYSICIAN: 4 Nursing Name 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT marked, 28b. TIME OF INJURY 28d. DESCRIBE NOW INJURY OCCURED Natural 5 Pending Investigation М BY 1 YES 2 NO After t 2 Accident 26a. PLACE OF INJURY — Al home, farm, street, factory, office building, atc. (Specify) Sulcide 28 is ETED. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be DIRECTOR: / 4 Nomicide determined 29a. CERTIFIER COMPL CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(e) end manner as stated. TO THE FUNERAL DE FILE FUNERAL DE FILE WITHIN 72 N (Check only one) 2 MEDICAL EXAMINER: On the beale of examination and/or investigation, in my opinion, death occurs at the time, date and place, and due to the cause(e) and manner as stated. BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Mover, Con. Year) 0 D 19155 4 2 38. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MARK KAPLAN, M.D., 16918 YORK ROAD MONKTON, MARYLAND 21111 31. DATE FILED (Month, Day, Year) JUL 0 7 1995 32. REGISTRAR'S SIGNATURE

American Street Barrier Street TOTAL BUT OF THE STATE OF THE S SACTOR AND A STATE OF THE ASSESSMENT OF THE

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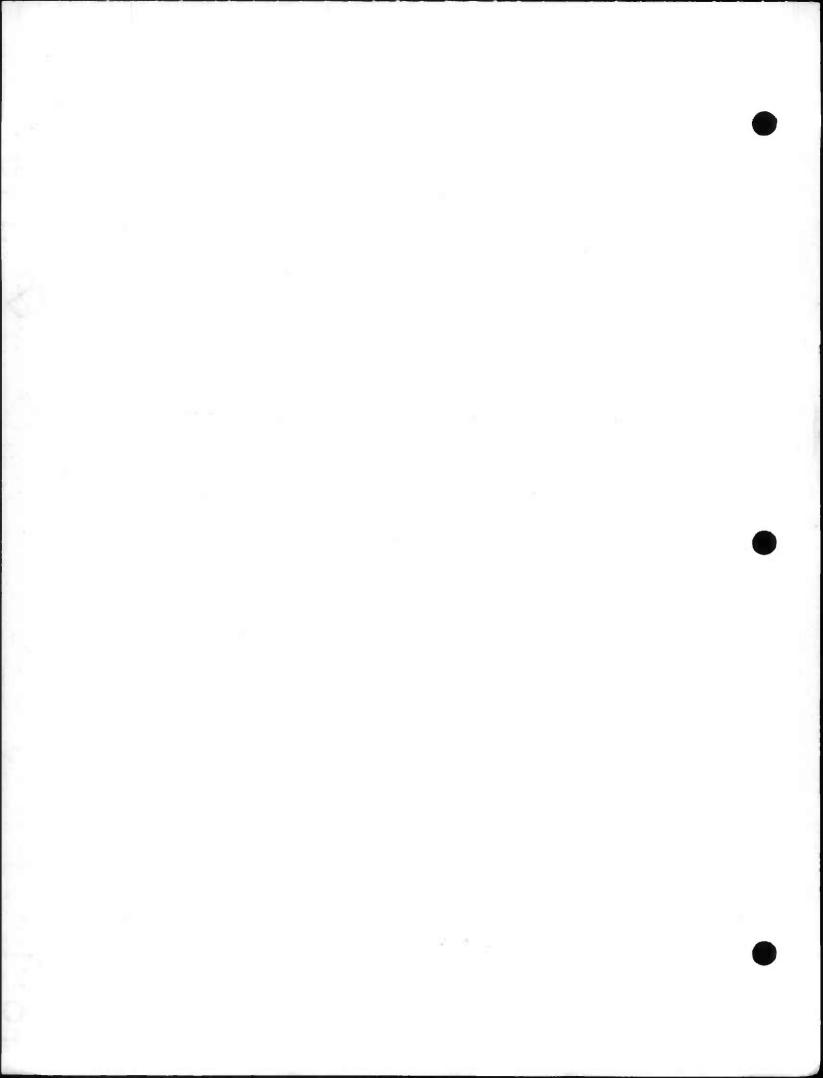
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	remation, or removal.	ent, the medical examiner must be notified at once.
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certifical	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending phy	/ be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR														
	ERNE	ST	DANI	ELS						Jun	e 15°	, 19	95	12:45 a.m	
	4. SOCIAL SECURITY NUME	ER	5. SEX	6. AGE (In yrs. la	st birthday)	IF UNDER	-	IF UNDER		7. DATE OF BIRTH A(Month, Day Mer) Apr. 18, 1918 Ark			HPLACE (State or Foreign		
	429-05-2730		1 📆 M 2 🗌 F	77	YRS.	MONTHS	DAYB	HOURS	MIN.	Apr	.18",	1918	Ar	kansas	
	9a. FACILITY NAME (If not in		9b. CITY	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEA						DEATH					
E	Grosvenor	Hea1	th Care	e Cente	er	5721 Grosvenor Lane Montgo						omery			
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY														
DIRECTOR	D.C.		v, town (Wast		ion Iton						10d. INSIDE CITY LIMITS?				
	10a. STREET AND NUMBER	110	one					r. ZIP COD					TX YES 2 NO		
FUNERAL	340 Nic	7		"		001	10g, CITIZEN OF WHA								
¥	11. MARITAL STATUS	HOTSC	12. WAS DECEDEN			13.	WAS DEC				(Specify Yes	J	_	E American Indian.	
	1 ☐ Never Married 2 ☐ Married FORCES? 1 ☐ YES 2 ☑ No.						If yes, sp	ecify Cubs	n, Maxica	n, Puarto R			Blec	k, White, etc.	
BY	3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 3 NO Specify: Specify:										Black				
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working														
COMPLETED	Elamentary/Secondary (0)-12)	College (1-4 or 5	+}	. Do NOT us	e retired.)					cade			ne	
AP.	7 Auto Mechanic Laundry Co.														
	17. FATHER'S NAME (First, Middle, Last) Harry Daniels Louisa Warren														
BE	Harry		inters												
9	19a. INFORMANT'S NAME (Type/Print) Bernice Daniels wife 19b. MAILING ACCRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 340 Nicholson St.N.E.Wash.D.C.20011												011		
	20a. METHOD OF DISPOSITION 1 M Burlai 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, cramatory or other place)														
	4 Donation 6 Other (Specify) Harmony Memorial Park 6/20 Landover, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hunt Funeral Home														
	1 7 g	?ama	end 2	trant	_					П				Home 20020	
	23. PART I, Enter the d	Season or	complications the	WIN	eeth Do n			_							
	ahock, or h	eart failure.	List only one car	use on each line	e,	iot viitoi		de or dy	mg, auci	11 99 CG1G	ec or resp	natory a	rest,	Approximate Interval Between	
	IMMEDIATE CAUSE (Final disease or condition SEPSIS														
	reaulting in deeth) s. SEFSIS OUE TO (OR AS A CONSEQUENCE OF):														
2															
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF):														
S	CAUSE (Disease or injury														
	that initieted events		DUE TO	(OR AS A CONSE	OUENCE OF	F):									
H	d,														
	PART ii. Other significe	nt condition	s contributing to	death but not	resulting i	in the u	nderlyin	g ceuse	given in	Part i.	24a. WAS AN	N AUTOPSY 24b, WERE AUTOPSY		. WERE AUTOPSY FINDINGS	
EDICAL	Hypert	ensid	on							_	PERFO			AVAILABLE PRIOR TO COMPLETION OF CAUSE	
밀	CVA									_	1 123	MO NO		DF DEATH? 1 YES 2 NO	
¥.										_				1 1 10 1 10	
NA I	25. WAS CASE REFERRED T	O MEDICAL					26. P	LACE OF D	EATH (Ch	eck only one)				
Sic	EXAMINER?		HOSPITAL: 1 Inpatient 2	☐ ER/Outpatient :	3 DOA	OTHE		10 5 🗆 Ri	sidence	6 Other	(Specify)				
PHYSICIAN:	27. MANNER OF DEATH		28a. DATE OF (Month, E		26b. TIM		28c. IN.	JURY AT			CRIBE HOW	NJURY O	CURED		
ВУ		Pending Investigation	(Morior, C	ouy, roury	143	M		YES 2] NO						
	3 Suicida 8	Could not be	28a. PLACE (OF INJURY — At he atc. (Specify)	oma, farm, s	straet, fac	tory, offic	a .			TION (Street or Town, State)		or Or Rural	Route Number,	
1	4 Homicide	detarmined		, (-),//						Oily C	v vown, Giele,				
COMPLETED	29a. CERTIFIER (Check only	riFYING PHYSI	ICIAN: To the best or	f my knowledge, d	eath occum	ed at the	time, data	and place	, and dua	to the cau	e(a) and ma	nner aa at	nted.		
MO	anal													a) and manner as stated.	
	296. SIGNATURE AND TITLE	OF MATTERES	1	/				29c. LIC	ENSE NUN	ABER		294. DA	TE SIGNES	(Morsh, Day, Year)	
) BE	W.	Χ.	216					De	35	18		Þ 0	June	19,1995	
2	30. NAME AND ADDRESS OF	F PENGON WH	O COMPLETED CAL	SE OF DEATH (ITE	M 27) /7pm	Print)						1		/	
	Elliot R.	601d		4410	old	66	2010	se to	WX	Rd	*	2941	MA	1 (11) 20814	
Elliot R. Goldstein 9410 Old George fown Rd Betherda															
	31. DATE FILED (Month, Day,	1	32, REGISTRA	AR'S SIGNATURE											

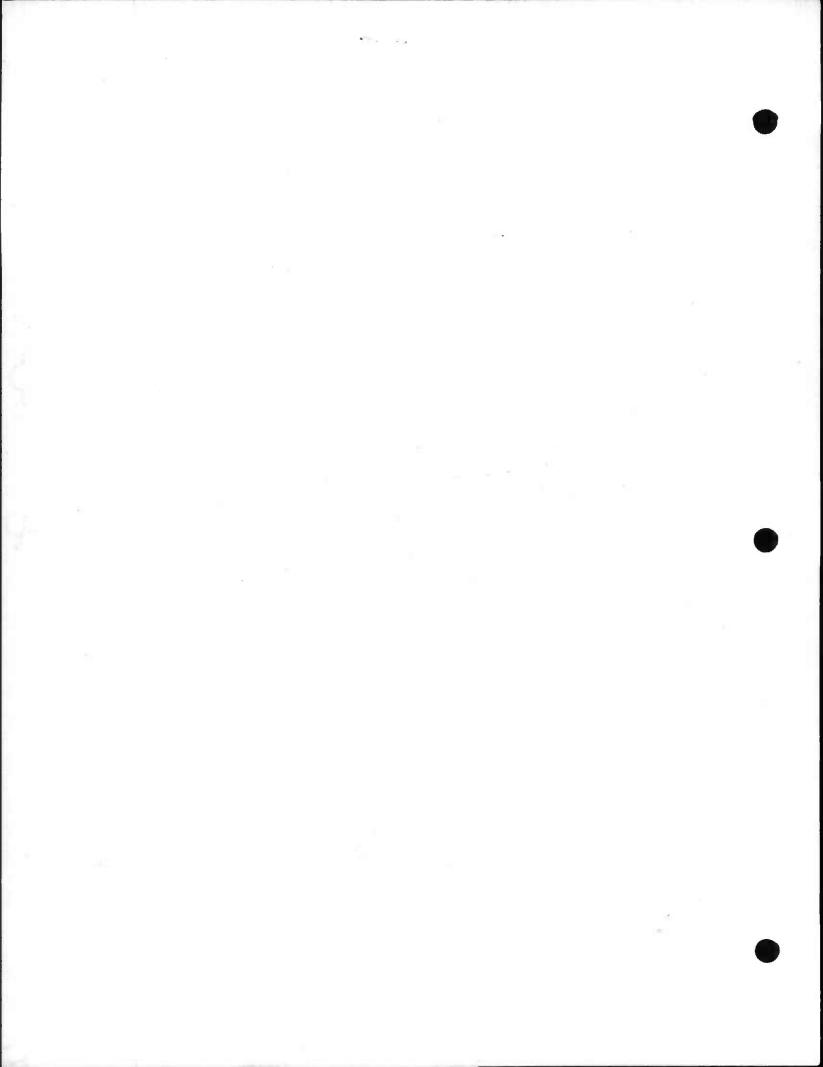


FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MAdeline JOAN 120 p M JUNE. 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) 1 M 2 F HOUSE 064-05-3092 July 27, New York Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Fallston General Hospital Fallston Harford RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Harford Edgewood 1 - YES 2 1 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 1924 Harewood Rd 21040 USA retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 1 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indien, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married If yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: BY Specify. 3 Widowed 4 Divorced White ETED 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hi COMPL 8 Purchasing Agent Hospital 17, FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) Carmel (nmn) Del Balzo notified at (nmn) Carmella LaVia BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Christine Moore 1924 Harewood Rd., Edgewood, Md. 21040 Page 6 may be Pe 20a. METHOD OF DISPOSITION
1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must Air Memorial Gardens 6-30-95 4 Donation 5 Other (Specify) Bel Air, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICEN examiner 22. NAME AND ADDRESS OF FACILITY hours after death. Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. the attending physician and completely filled in by the Mental Hygiene prior to burial, cremation, or removal. 21009 medical 23. PARTY. Enter the disease, or complications that coused the deeth. Do not enter the mode of dying, such as cerdiac or reopiratory arrest, ahock, or heart feliure. List only one ceuse on each line. interval Between Onset and Death IMMEDIATE CAUSE (Fine) the disease or condition DUE TO (OH AS A CONSEQUENCE OF): 101 resulting in death) event, the death certificate be executed with DIVISION OF VITAL RECORDS, P.O. BOX 68760 >54 traumatic 860 CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 Injury. PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS signed by t AVAILABLE PRIOR TO COMPLETION OF CAUSE amy cardiar antisthing 1 YES 2 NO OF DEATH? shows 1 TYES 2 NO ъ DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN PHYSICIAN: Dept. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) DR ATTENDING PHYSICIAN: The tem DIRECTOR: After this certificate I hours after death with the State HOSPITAL:
15 Inpetient 2 ER/Outpetient 3 DOA OTHER: 1 TYES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 6 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH marked, 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural М 1 YES 2 NO BY 2 Accident
3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 00 ETED 6 Could not be 4 Homicide 28 29a. CERTIFIER (Check only CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. COMPL TO THE HOSPITAL OF THE FUNERAL DE SE SIED WITH 72 M HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end pieca, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 6/27 032295 2 30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVAD 5. 1131 Belaic

31. DATE FILED (Month, Day, Year)

JUN 2 8 1995

32 REGISTRAR'S SIGNATURE



DIRECTOR

FUNERAL

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28 is marked,

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE 0 3 Suicide

4 Homicide

29e, CERTIFIER

permit. Pages 1, 2, 3

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60. BALTIMORE, MARYLAND 21215-0020	with nours after death. Page 6 may be retained by the hospital or attending p	ppletely filled in by the funeral director, page 5 should be detached for use as the committion, or removal.	vent, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760.	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hospital or attending physici	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial: be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) ANN GWYNN deMNRGUIONDO demurquiondo ann JUne gwynn 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year 10/4/10 6. AGE (In yrs. last birthday IF UNDER 1 YEAR DAYS HOURS 213-30-7688 1 M 2 K 62 Maryland 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Maryland Baltimore Monkton 1 YES 2 NO 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2803 Corbett Road 21111 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuben, Mexicen, Puerto Ricen, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR OATES 1 Never Merried 2 Merried Specify: 3 Widowed 4 Divorced Caucasian 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use refired.) 16b. KINO OF BUSINESS/INDUSTRY (Specify only highest intary/Secondary (0-12) College (1-4 or 5+) Housewife Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumame) Edwin Ross Pearce Anna Frankenfield 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) Ann C. Lonegan Monkton, Corbett Rd. Maryland 2111 20e. METHOD COSPOSITION
1 Burlel 2 Cremetton 3 Re
4 Donation 5 Other (Specify) 20b. PLACE AND OATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State ery, crematory or other place)
Arroll Cremation Hampstead Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADORESS OF FACILITY Kurtz Funeral Home Jarrettsville. Maryland 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximsta shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onsat and Dasth disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF)

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 - YES 2 100

28d. DESCRIBE HOW INJURY OCCURED

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

Ø

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 YES 2 NO

DID TOBACCO USE CONTRIBUTE 1	TO CAUSE OF DEATH	YES NO	UNCERTAIN
WAS CASE REFERRED TO MEDICAL	26 BLACE OF	OFATH (Check anti-con)	

DUE TO (OR AS A CONSEQUENCE OF)

EXAMINET HOSPITAL: OTHER: 1 YES 2 1 | Inpatient 2 RA/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify)

27. MANNER OF DEATH 1 Natural 2 Accident

28e. PLACE OF INJURY — At home, ferm, street, tectory, office building, etc. (Specify) 6 Could not be determined

28e. OATE OF INJURY 26b. TIME OF 28c. INJURY AT WORK? 1 YES 2 NO

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) end menner ee stated,

of exemination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) and menner ee stated,

Elizabet On	muellace
HAMP AND ADORESS OF PERSON WHO COMPLETED	CAUSE OF DEATH (ITEM 27) (Type, Print)

JUN 2 8 1995

29d. DATE SIGNED (Month, Day, Year)

DHMH-16 Rev 1/89

.... FFEE . Since A Town

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2. Murs after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely. All in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. DIVISION OF VITAL RECORDS, P.O. BOX 13146,

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

REGISTRAR		CERTIFIC	ATE OF DE	ATH	RE	G. NO.		
. 1. DECEDENT'S NAME (First, Middle, La					2. DATE OF DE	DAY	YEAR 3. TIME OF	SOP
Leroy R. Eyler 4. social security number 215-26-9117	5. SEX 8. AGE		UNDER 1 YEAR IF	INDER 24 HRS. IRS MIN.	7. DATE OF BIT (Month, Day, Oct. 17	TH	a. BIRTHPLACE (State Country)	
	50.27 Babylon Rd. 5027 Babylon Rd. 5028 Babylon Rd. 5028 Babylon Rd. 5028 Babylon Rd.					9c. COUN	arroll	
10s. STATE 10b. COL	10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION						10d. INSIDE LIMITS 1 TES	37 /
100. STREET AND NUMBER 5027 Babylon	Road		10f. ZIP 217			US:	ZEN OF WHAT COUNT	'RY?
11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 TYES IF YES, GIVE WAR OR	2 [] NO			n, Puerto Rican,		14. RACE — American Black, White, atc. Specify: Whi	
15. DECEDENT'S (Specify only highest g		16a. DECEDENT'S US	UAL OCCUPATION done during most of stired.)	working	16b, KIND	OF BUSINESS/IND	USTRY	
Elementary/Secondary (0-12)	College (1-4 or 5+)		Die Maker		Mani	ıfacture	Office F	urnit
17. FATHER'S NAME (First, Middle, Last)						Maiden Surname)	1100	
Jesse F.W.Eyl	er	19b. MAILING AD	DRESS (Street and N		Isan Sha		Code)	
Dorothy C.Eyl	er	5027 Bal	oylon Rd.	Taneyt	own, MD2	21787		
20s. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 1	Removal from State	0b. PLACE OF DISPOSITI				20c. LOCATION —		
4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE	E LICENSEE	Rocky Hi	22. NAME AND A	DDRESS OF FA	CILITY	Moodsbor	ttlestown	244
IMMEDIATE CAUSE (Fine) disease or condition resulting in desth) B. GLIOBLASTOMA MULTIFORME JVEAR DUE TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF):								
if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	cDUE TO (OR AS	A CONSEQUENCE OF):						0.77
PART II. Other eignificent cond	tions contributing to death	but not resulting in	the underlying ca	use given in		WAS AN AUTOPSY PERFORMED? YES 2 NO	24b. WERE AUTO AMAILABLE COMPLETIO OF DEATH? 1 YES	PRIOR TO ON DF CAUSE
25. WAS CASE REFERRED TO MEDICA	1		26 PLACE	OF DEATH (C)	eck only one)			
EXAMINER?	HOSPITAL:	utpatient 3 DOA 4	THER:			octfy)		
27. MANNER OF DEATH	25a. DATE OF INJURY (Month, Day, Year)	Y 25b. TIME C	OF 28c. INJURY WORK?	AT		E HOW INJURY OC	CURED	
2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	28e. PLACE OF INJUI	RY — At home, farm, stre		2 NO	281. LOCATION City or Tox		r or Rural Route Number	ď,
(Critick Orlly /	HYSICIAN: To the best of my known MINER: On the bests of examinate							er as stated
296. SIGNATURE AND TITLE OF CERT	s DKas	up mo	1	LICENSE NU	MBER 0054		E SIGNED (Month, Day,	
30. NAME AND ADDRESS OF PERSON		Broadway I	int)					

Not it met it met

3. TIME OF DEATH

5:55 PM

8. BIRTHPLACE (State or Foreign

Washington, DC

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

Specify:

USA

1 YES XX NO

White

Interval Betw

OF DEATH?

Onset and Death

Pages 1. 2, 3 should

permit.

DIRECTOR

FUNERAL

BY

COMPLETED

2

CERTIFICATION

PHYSICIAN: MEDICAL

BY

COMPLETED

BE 2

28 18

other

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Sequantially list conditions,

If any, leading to immediate

cause, Enter UNDERLYING CAUSE (Disease or Injury

that Initiated events resulting in death) LAST

notified at BE (

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examiner

n and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit to burial, cremation, or removal. signed by the attending physician Health and Mental Hygiene prior to has b OR ATTENDING PHYSICIAN: The law certificate h this c After death DIRECTOR: / TO THE HOSPITAL TO THE FUNERAL IS be filed within 72 h HOSPITAL

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last 2. DATE OF OEATN JUNE 22, ROGER ALLEN EVERSTINE JR 1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. lest birthdey 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS March 13 1960 213-82-4988 1XX M 2 1 35 9a. FACILITY NAME (If not institution, give stre 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Route 1 Box 449-D CHARLES Indian Head RESIDENCE OF DECEDENT 10b. COUNTY 10c, CITY, TOWN OR LOCATION Maryland Charles Indian Head 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Route 1 Box 449-D 20640 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 THOO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Ri

1 YES 2 NO Specify: 1 Never Married 2 X Married 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION sectly only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Spe College (1-4 or 5+) 12 Store Worker Produce Sales 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) Roger Allen Everstine Sr Violet A. Dickerson Everstine 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route_1 Box 449-D Indian Head, MD 20640 В. Margaret Everstine 20a METHOD OF DISPOSITION
WABurlel 2 Cremation 3 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Bells U.M. Church Cemetery 6-26-95 Camp Springs, MD 21. SIGNATURE OF FUNERAL SER 22. NAME AND ADDRESS OF FACILITY M00173 J.H. Eberwein Mortuary 4433 White Pls La White Pls, MD 20695 23. PART. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or haart fallure. List only ona cause on each line IMMEDIATE CAUSE (Finel disease or condition_ SCIZWE ason reaulting in death) DUE TO (OR AS A CONSEQUENCE OF)

DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? 1 TES 2 NO

DID TOBACCO USE CO	NTRIE	BUTE TO CAUSE OF DEA	TH Y	ES 🗆	NO UNCERTA	UN 🗆		1 TES 2 NO
25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 YES 2 NO	Н	26. PLACIOSPITAL:		OTHE	conly one) R: Insing Nome 5 Residence	e 6 🗆 Other	(Specify)	
27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Inventige	lon	26a. DATE OF INJURY (Month, Day, Year)	26b. TIN	NE OF JURY M	28c. INJURY AT WORK? 1 YES 2 NO	26d, DESC	CRIBE HOW INJURY OCC	CURED
3 Suicide 6 Could no 4 Nomicide determin		28e. PLACE OF INJURY — At he building, atc. (Specify)	ome, farm,	street, fac	ctory, office	261. LOCA City of	TION (Street and Number Town, State)	or Rural Route Number,

29a. CERTIFIER	4 T OFFICIAL PRINCIPLE TO THE PRINCIPLE	
(Check only	CERTIFYING PHYSICIAN: To the best of my knowledge,	death occurred at the time, data and place, and due to the cause(s) and menner as stated,
one)	a Circles and a second	

2 MEDICAL EXAMINER: On	the basis of examination and/or investigation, in my opinion, d	eath occured at the time, data and place, an	nd due to the cause(a) and manner as stated.
GMATURE AND TITLE OF CERTIFIER		20- LICENSE MUNICIPA	

290. SIGMATURE AND TITLE OF CERTIFIER	Charles a Annie Me	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)

Hat	PD	Box	1647	Waltert	py	20862
-----	----	-----	------	---------	----	-------

32. REGISTRAR'S SIGNATURED 31. DATE FILED (Month, Day, Year) JUN 2 6 1995

hours after death. Page 6 may be retained by the hospital or attending physician. et in the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

FUNERAL

BY

COMPLETED

BE notified

2

once.

76

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must

medical examiner

the

traumatic event,

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

2

resulting in death) LAST

1 YES 2 NO

5 Pending

Thomas E. Finucan

8 Could not be

Investigation

27. MANNER OF DEATH

1 Natural

2 Accident

3 Suicide

4 Nomicide 29a. CERTIFIER

(Check only one) 29b. SIGNATURE

completely filled in by the rial, cremation, or removal,

Hygiene prior to burial, cremation, or

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	H.VS	his c	with	ked,
Z	NG P	ther t	eath	mar
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5	8	DIR	Pour	Ten
	M	RAL	2	=
	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and complete	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, crem	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event,
	FE	THE	filed	POR
	2	2	å	Σ

95 20620 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH 1995 Everett Farmer June 25 9:25 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 1 X M 2 | F YRS. 166-16-1359 83 March 31 Tennessee 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Laurelwood Nursing Center E1kton Cecil RESIDENCE OF DECEDENT 10b. COUNT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Ceci1 E1kton 1 X YES 2 NO 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 100 Laurel Drive 21921 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. RACE - American Indian, 1 Never Married 2 Married 1 ☐ YES 2 X NO Specify: Specify: White 3 🔀 Widowed 4 🗌 Divorced 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Construction/Masonry Elementary/Secondary (0-12) College (1-4 or 5+) 6 Stone Mason Self-Employed 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) David Farmer Victoria Payne 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miriam N. Funk 316 D Nottingham Road, Elkton, MD 20a. METHOD OF DISPOSITION
1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Bethel Cemetery 4 Donation 5 Other (Specify) 6/27 | North East, Maryland 21. SIGNATURE OF FUNERAL SERVINE LICENSEI 22 NAME AND ADDRESS OF FACILITY.
Crouch Funeral Home South Main Street, North East MD 21901 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate ahock, or heart fallura. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition Me distate CA reaulting in death) DUE TO (OR AS A CONSEQUENCE OF) Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate e. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa DUE TO (OR AS A CONSEQUENCE OF):

DID TOBACCO USE CONTI	RIBUTE TO CAUSE OF DEATH	YES 🗆 NO 🗆	UNCERTAIN
25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF	DEATN (Check only one)	

PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i.

26. PLACE OF DEATH (Check only one)

HOSPITAL: OTHER: Inpetient 2 - ER/Outpetient 3 - DOA 4 - Nursing Nome 5 - Residence 6 - Other (Specify)

28a. DATE OF INJURY

28b. TIME OF INJURY 28c. INJURY AT WORK?

1 YES 2 NO 28a. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify)

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

D32395

24s. WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO

28d. DESCRIBE HOW INJURY OCCURED

_	CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(s) and manner as stated
\Box	MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my op	pinion, death occured at the time, data and p	place, and due to the cause(e) and manner as stated.
AND TITLE OF STITUTES	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)

	ya	ζ.	-	_		
O. NAME AND	ADDRESS OF PE	RSON WHU	CUUI LETED	CAUSE OF	DEATN (ITEM 27)	(Type, Print)

3	Mauldin	Avenue	North	East	Man	land	2190
12. REG	ISTRAR'S SIGNATURE					1	

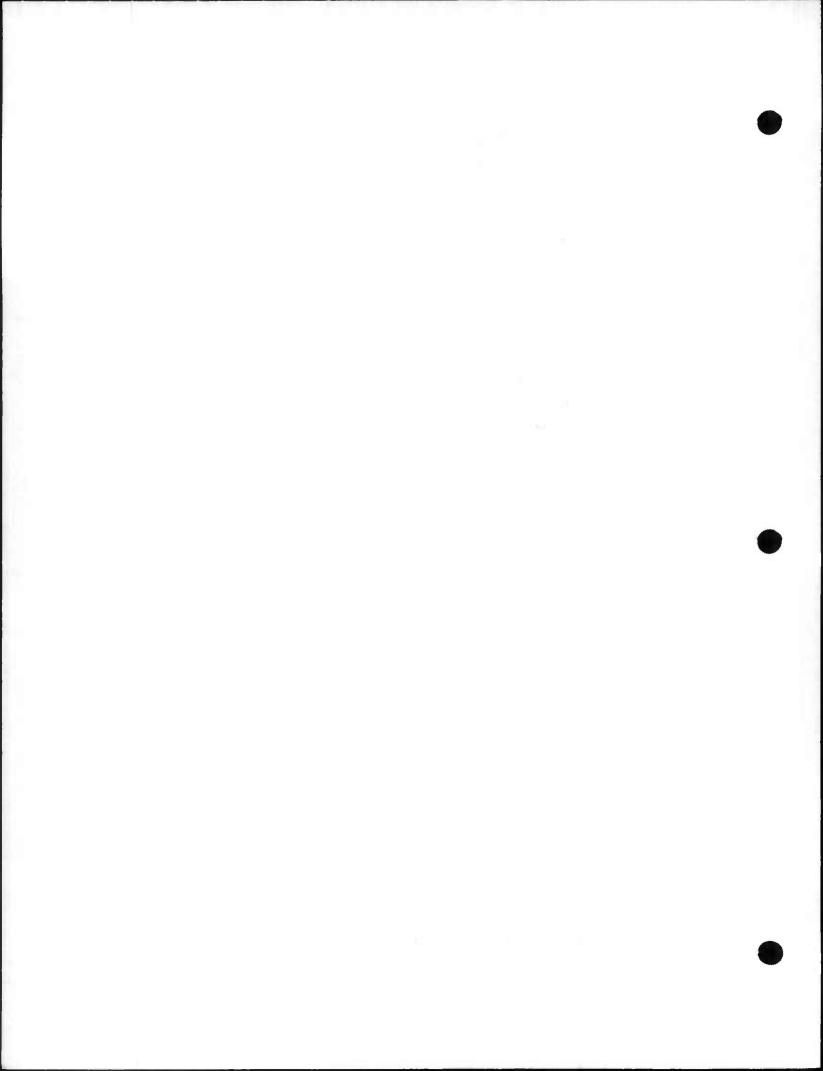
his Daveles Rardall

DHMN-16 Rev 1/89

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

OF DEATH? 1 TYES 2 T NO

June 26, 1995



AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Fowler

32. REGISTRAR'S SIGNATURE Davidson Randall

111

	s 1 2 3 should		
	of permit Page		
ling physician.	the burial-trans		
spital or attend	hed for use as		
ined by the ho	hould be detact		fled at once
6 may be reta	ector, page 5 sl		must be not
ifter death. Page	, the funeral dir	noval.	sai examiner
IAN: The law requires that the death certificate be executed within ea hours after death. Page 6 may be retained by the hospital or attending physician.	letely filled in by	emation, or ren	nt, the medi-
e be executed w	sician and comp	rior to burial, c	traumatic eve
death certificat	e attending phys	lental Hygiene p	ury, or other
equires that the	en signed by th	of Health and M	hows any inj
CIAN: The law r	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-traner nermit. Pages 1.2 s.	th the State Dept. of Health and Mental Hygiene pric	ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,
ENDING PHYSI	D THE FUNERAL DIRECTOR: After this certif	ter death with 1	8 is marked,
TO THE HOSPITAL OR ATTENDING PHY	IERAL DIRECT	be filed within 72 hours after death with	APORTANT: If item 28 is marke
D THE HO	THE FUR	be filed with	IMPORTAL

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR	STATE OF I		/ DEPAR					MENTAL	HYGIEN	E			
1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF				3. TIME OF DEATH	
DENNIS S	INIS SCOTT FOLLETTE							JUNE	TONE T9 1995 9:10 A				
4. SOCIAL SECURITY NUMBER	5. SE X	8. AGE (In yrs.	last birthday)	IF UNDER 1		IF UNDER		7. DATE OF	7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign				
213-04-3879	1 M 2 - F	30	YRS.	MONTHS	DAYS	HOURS	MIN.	April	2.2 . 1	965	Mic	higan	
9e. FACILITY NAME (If not institution, give s	reet and number)			9b. CITY, T	OWN C	R LOCATI	ON OF DE		,		NTY OF D		
WASHINGTON ADVENTIST HOSPITAL Takoma Park										MO	NTG	OMERY	
10a. STATE 10b. COUNTY	,		10c. CIT	Y, TOWN OR	LOCAT	ION						10d. INSIDE CITY	
D.C.			Was!	hingto	on,	D.C						LIMITS?	
10e, STREET AND NUMBER					101	ZIP COD	E			10g. CIT	IZEN OF V	WHAT COUNTRY?	
7411 - 9th Street	, N.W.				2	0012				U	SA		
11. MARITAL STATUS	12. WAS DECEDEN			13. W	S DEC	ENDENT (OF HISPAN	NIC ORIGIN?	Specify Yee	or No-	14. RACI	E — Americen Indian,	
1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1		NO			ecify Cube 2X NO		in, Puerto Ric y:	an, atc.)		Speci	k, White, etc.	
3 Widowed 4 Divorced												" Black	
15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	18e. I	Give kind of	USUAL OCC	UPATIO	ON at of worldi	na		IND OF BUS	100			
Elementary/Secondary (0-12)	College (1-4 or 5		ife. Do NOT us	se retired.)								vices	
12	2 1/2	N	arrat	or				То	urmo	bi1	9		
17. FATHER'S NAME (First, Middle, Last)								ME (First, Mid		Sumame)			
Lysle S. Folle	tte, Jr							e Hun					
Dr. Lysle S. Follette, Jr. Silver Spring, MD 20906													
20e. METNOD OF DISPOSITION		20b, PLAC	E AND DATE	F DISPOSIT	ON /Na	me of		DATE	7	CATION —	City or To	wn, State	
1 Suriel 2 Cremetion 3 Remarks A Donatton 8 Other (Specify)	oval from State	F t	Linc	oin (Cer	nete	rv	6/23	Bre	entw	boo	, MD	
21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE							Funer					
. J. P. mars	lall	,		430	8 C	Sui	t1a	nd Ro	d.,St	iit1	and	,MD 20746	
23. PART I. Enter the disease, or of ahock, or heart failure.	omplications tha	t ceused the	death. Do n	ot enter th	e mo	de of dy	ing, suc	h aa cerdia	c or reepin	ratory an	rest,	Approximate	
IMMEDIATE CAUSE (Final	ciet only one cao	ise on each in	16.									Interval Between Onset and Death	
disease or condition resulting in death)	MITRAL	VALVE PRO	LAPSE	AND AOF	TIC	INSU	FFICI	ENCY					
	DUE TO	(OR AS A CONS	EQUENCE OF	7:							_		
Sequentially list conditione, if any, leading to immediate	DUE TO	(OR AS A CONS	EOUENCE OF	7):									
CAUSE (Disease or Injury	-												
thet initiated events	DUE TO	(OR AS A CONS	EOUENCE OF	ን:									
resulting in death) LAST	ı												
PART II. Other eignificent condition	s contributing to	deeth but not	reeulting I	n the unde	rivino	Ceuse (riven in	Part i 2	Ia. WAS AN	HITTOPSY	7 246	WERE AUTOPSY FINDINGS	
					,	,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		PERFOR		240	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
					_			1	YES 2	□ NO		OF DEATH?	
DID TOPACCO LIST CONTE	IDI ITT TO CA	LICE OF DE	ATTA NOT	• 🗆								1 YES 2 NO	
DID TOBACCO USE CONTR	IBUIE 10 CA					UNC	ERTAIN						
EXAMINER?	HOSPITAL:		ACE OF DEAT	OTHER:	y one)								
1 TYES 2 NO	1 Inpatient 2E			4 🗆 Nursin			sidence	8 Other (S	Specify)				
27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED													
2 Accident Investigation M 1 YES 2 NO													
3 Suicide 8 Could not be determined	286. PLACE O building,	F INJURY — At I atc. (Specify)	nome, ferm, s	treet, factory	, office			28f. LOCATI City or	ON (Street al Town, State)	nd Number	or Rural F	loute Number,	
29a, CERTIFIER													
(Check only													
2 MEDICAL EXAMINE	On the page of 61	minuted end/o	r investigation	n, in my opir	iion, di	eath occur	ed at the	time, date an	d piece, end	due to th	e ceuse(s) end menner ee stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER		//				20- 1105	NSE NUN	IDED		29d. DAT			

O.C.M.E.

Penn Street, Baltimore, Maryland 21201

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires t TO THE FUNERAL DIRECTOR: After this certificate has been signe be filed within 72 hours after death with the State Dept. of Health

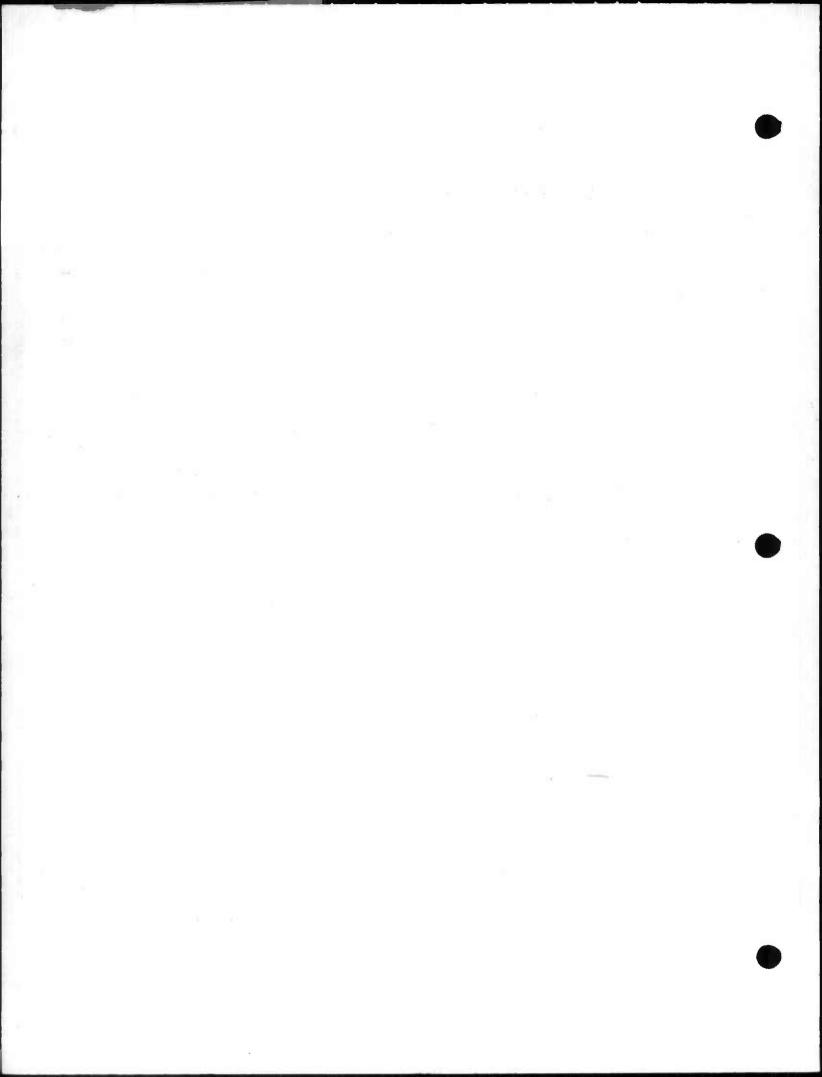
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

ILIN 22 1995

DHMH-18 Rev 1/89

▶ JUNE 20,1995



TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

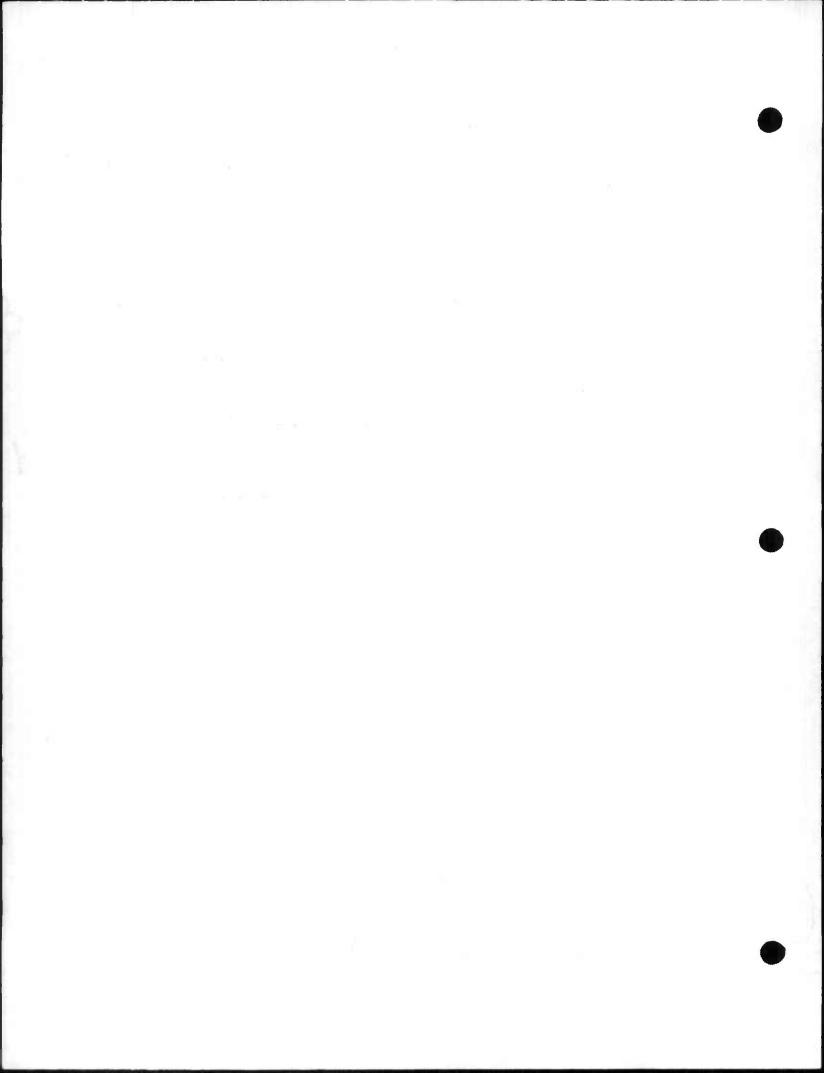
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH PEG NO.

_	* REGISTRAR		CERTIF	ICATE O	F DEATH	REG. NO).	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
1	Charles C.	Fleet Sr.				Jume 19	3 1995	13:40 P M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. A	GE (In yrs. last birthday)	IF UNDER 1 YEA	R IF UNDER 24 HRS.	7. DATE OF BIRTH	6. BIR	HPI ACE (State or Foreign
1 1	577-20-8922	1 📉 M 2 🗆 F	93 YRS.	MONTHS DAY	B HOURS MIN,	(Month, Day, Year)		D.C.
	9a. FACILITY NAME (If not institution, give :		,,,	Sh CITY TOW	N OR LOCATION OF I		901 Was	1 0
œ	Washington Adver	itist Hospi	tal	Takoma	Park, M	d.		
DIRECTOR	RESIDENCE OF DECEDENT	10130 110391		14.101111			Montgo	liery
입	10e. STATE 10b. COUNT	Υ	10c. CI	TY, TOWN OR LO	CATION			10d. INSIDE CITY
<u> </u>	DC	NH						LIMITS?
	10e. STREET AND NUMBER		was	<u>shingtor</u>				1 X YES 2 NO
\ ₹	6415 2nd. Place	N. I.I			10f. ZIP CODE			WHAT COUNTRY?
FUNERAL					20012		USA	
5	11. MARITAL STATUS	12. WAS DECEDENT EVEN	ER IN U.S. ARMED			NIC ORIGIN? (Specify Yes	s or No — 14. RA	CE — American Indian, ck, White, etc.
BYF	1 Never Married 2 Merried	World War	R PATES		ES 2 X NO Spec	en, Puerto Rican, etc.) iiy:		
	4VV mones 4 Photosa	I world war	11		-		Blac	C K
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S	Work done during	TION most of warking	16b. KIND OF BU	SINESS/INDUSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT	ise retired.)	most or working			
틸	10th.		Securit	y Guard	1	U.S. Go	vernmen	t
S S	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S N	AME (First, Middle, Maiden	Sumeme)	
	William C. Fle	et			France	es E. Barke	ar	
BE	19a, INFORMANT'S NAME (Type/Print)		19h MAILIN	ADDRESS (Street		Route Number, City or Tow		
2	Carole D. Fleet					washington,		0012
	20e. METHOD OF DISPOSITION							
	V□ Burial 2 □ Cremation 3 □ Rem	noval from State	206. PLACE AND DATE COMMETTER, Cremetery, Cremetery Nony	of DISPOSITION other place)	(Name of		CATION — City or	- LCCC
	4 ☐ Donation 6 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI		Harmony N			6-22 Land	lover, Mo	1.
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE		Mars Mars	AND ADDRESS OF F	uneral Home	2	
- 11	1 VA Y	Jachs	00)	4217	9th St	N W Wach	ington	D.C. 20011
	23. PART (Enter the diseases, pr	complications that ceu	sed the death. Do	not enter the	node of dving eu	ch se cerdisc or man	retory errort	Approximate
H	ahock, or heart fellure.	List Dniy Dne cause o	n each iine,		g, so	on se cardiac or resp	matory arreat,	intarvai Between
	iMMEDIATE CAUSE (Final disease or condition	0	a -d -	~	1			Onset and Death
	resulting in death)		or ma	0	Mast			
		DUE TO TOR	AS A CONSEQUENCE O	NF3:				
Z	Sequentially list conditions,		Dich	les				
Ĕ	if any, leading to immediate	DUE TO OR	AS A CONSEQUENCE O	70	1 +			
걸	cause. Enter UNDERLYING CAUSE (Disease or injury	· 17	trul,	PW	Brief	~		
쁘	that initiated events	DUE TO (OR)	AS À CONSEQUENCE C	ALT Y		1	1	1
CERTIFICATION	resulting in death) LAST	4	evolo	-6	Cesul	was	Widen	+
O	PART II. Other significant condition	as contributing to deal	h hut not consisten	In the conducto	taa aassa atsaa t	2 at 1 at 1 at 1	1	7 1
DICAL	otto ognicani condition	is contributing to deal	in but not resulting	in the underly	ing cause given in	Part I. 24s. WAS AN PERFOR		b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
ă						1 [] YES 2	NO	COMPLETION DF CAUSE OF DEATH?
ME	å				-4-		1	1 - YES 2 - NO
	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH Y	ES NO	W UNCERTA	N 🗆	i .	WIA
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEA	TH (Check only or	10)			
S	EXAMINER?	HOSPITAL:	Outpatient 3 DOA	OTHER:	ome 5 🗆 Residence	& Commercial		
 	27. MANNER OF DEATH	28a, DATE OF INJU			NJURY AT	28d. DESCRIBE HOW I	N.IUDY OCCUBED	
	1 Natural 5 Pending	(Month, Day, Ye		JURY	WORK? YES 2 NO	200. DESCRIBE NOW I	NOON! OCCORED	
B	2 Accident Investigation	200 PLACE OF IN I	URY — At home, farm,					
	3 Suicide 8 Could not be 4 Homicide determined	building, etc. (Specify)	street, mctory, or	TICE	281. LOCATION (Street of City or Town, State)	and Number of Rural	Floute Number,
<u> </u>								
COMPLET	29e. CERTIFIER (Check only	ICIAN: To the best of my k	nowledge, death occur	red at the time, d	ete end place, and du	e to the cause(s) end mar	nner as atated.	
0	MEDICAL EXAMINE	R: On the basis of examin	ation end/or investigati	on, in my opinior	, death occured at the	time, date and piece, en	d due to the cause	s) end menner es stated.
	294 SIGNATURE AND TITLE OF CERTIFIE	R /			29c ACENSE NU	MBER	29d. DATE, SIGNE	D (M¢ntþ. Day, Ybar)
H	1 \ Daga	Ven	no			19/119	D	VIS
임	30. NAME AND ADDRESS OF PERSON WH	IO COMPLETED CAUSE OF	DEATH ATEM 27 CT	Print!	11/2	That	0	1110
	1000	a a C = C =	A. A.				1A A	Ph Man
	31. DATE FILED (Month, Day, Year)	VVOURDE	MS INV	129) (m	Renway	(X~ 8	(4) (A)
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S S	Julia Davidso	Redo		J		2777
	DI LIZZUN	21 1995	juva a wayo	N-MONOGAN,				20170

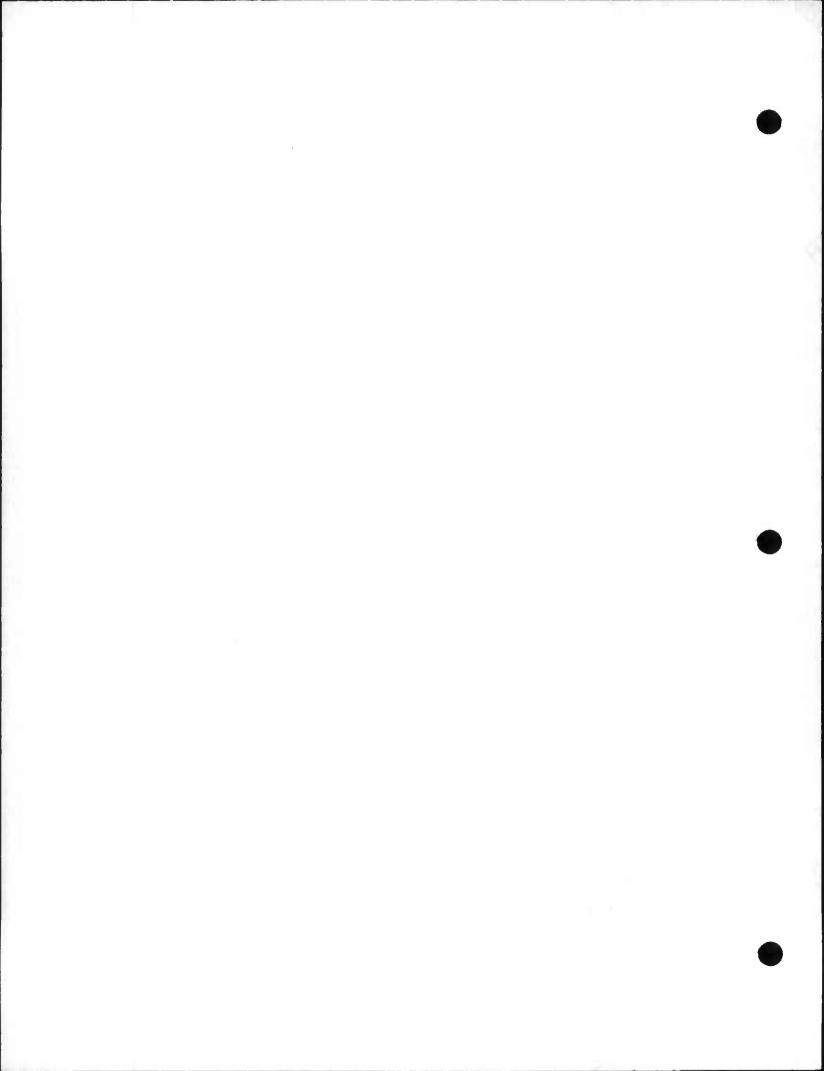


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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH YEAR LESLIE JUNE FARMER JR 1995 16 04:00 AM 4. SOCIAL SECURITY NUMBER 5 SEY 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 🔎 M 2 🗌 F 242-54-4540 56 31938 Wilson Aug N pinous 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Pages 1, 2, 3 Prince George's Hoipital Cheverly Prince George's 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD 1 YES 2 KNO permit. Prince George's Forestville 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 10a, CITIZEN OF WHAT COUNTRY? use as the burial-transit 8200 Bridlewood Place 20747 U.S.A retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Bleck, White, atc. 1 Never Married 2 Merried If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 YES 2 TO NO Specify: BY 3 Widowed 4 Divorced Specify: Black COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Spi funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) 12th Bus Operator Government once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) TE BE Leslie Farmer Mary Baines notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Irish Farmer Bridlewood Pl Forestville, Md 20747 must be 20a. METHOD OF DISPOSITION
1 □ Purial 2 □ Cremation 3 □ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State lery, cremetory or other place)
Leasant View CemeteryJun 4 Donation 5 Other (Specify). 22 Arrington, Va examiner 21. SIGNATURE DE FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 20785 hours after death. J.B. Jenkins Funeral Home 8) 7474 Landover Rd. Landover, completely filled in by the MD medicai 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiec or respiratory arrest, Approximata shock, or heart fellure. List only one cause on each line. Interval Between ö Onset and Death IMMEDIATE CAUSE (Final cremation. the state the death certificate be executed within 24 disease or condition Neck cheer Metastaho resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): prior to burial, CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury the attending physician Mental Hygiene prior to other 1 DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in deeth) LAST 6 injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? signed by the shows any 1 YES 2 NO OF DEATH? 1 ☐ YES 2 ☐ NO рееп 50 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 has 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Tem! certificate State HOSPITAL: OTHER: 1 YES 2 NO 1 Despetient 2 ER/Outpetient 3 DOA ng Home 5 Residence 8 Other (Specify) 6 the 27. MANNER OF DEATH 28a. DATE OF INJURY 26d. DESCRIBE HOW INJURY OCCURED this c marked, 28b. TIME OF 28c. INJURY AT WORK? 1 Natural 5 Pending Investigation 14 1 YES 2 NO death BY ATTENDING After 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 50 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be DIRECTOR: Nours after of 4 Homicide 200 8 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL TO THE FUNERAL (THE filed within 72 h HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Physician 041520 uno 2 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo. Print) TOWARD MORRES 8937 SKILL CO SKYrock Ct. Columbia, MD Howard 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

Davider Ranfall

JUN 20 1005



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

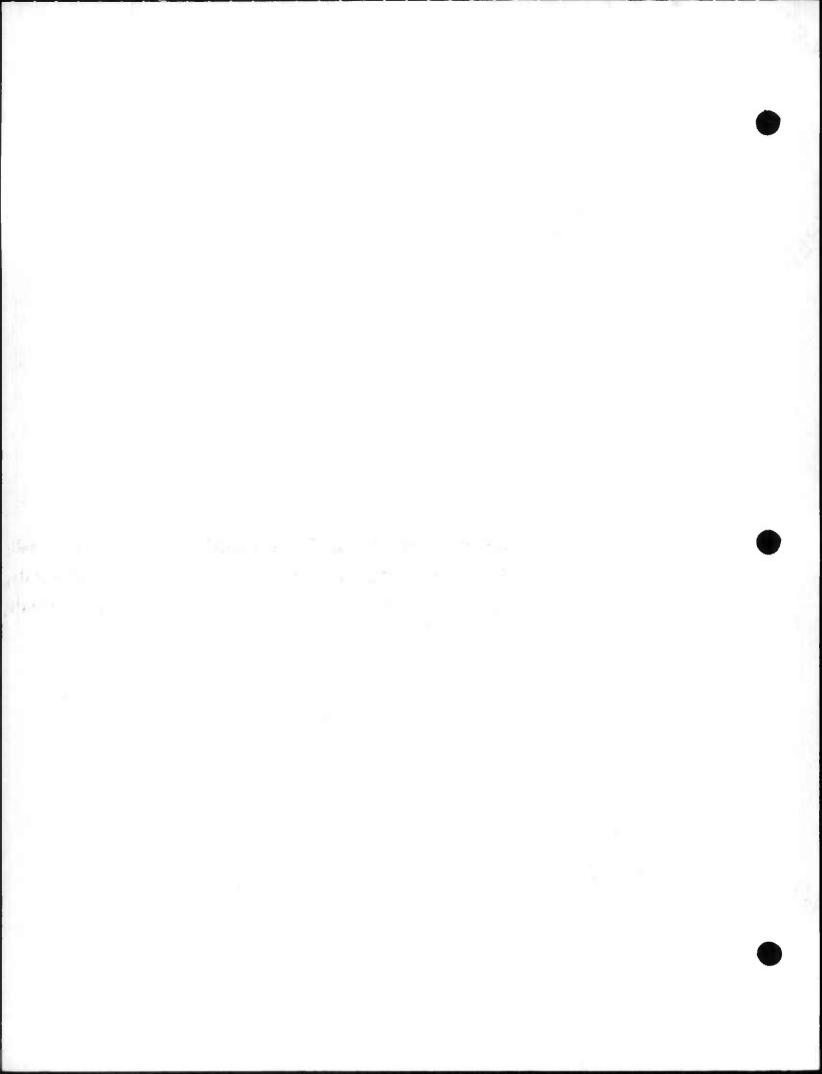
TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE

	REGISTRAR		CI	ERTIF	ICATE (OF	DEATH		REG. NO).			
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE (OF DEATH	MY	YEAR	3. TIME OF DEAT	TH
		RES						June			995	6:00	Рм
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. las	t birthday)	IF UNDER 1 Y	AR NYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE C	F BIRTH Day, Year)		8. BIRTI	HPLACE (State or Fo	oreign
	N/A	1 □ M 2 💢 F	0	YRS.		5	HOURS MIN.	May		1995		hington	, DC
~	Se. FACILITY NAME (If not institution, give a				9b. CITY, TO	WN O	R LOCATION OF D	EATH		9c. CO	UNTY OF		
5	4723 Bartram Str	eet			Rock	vi	11e			Mo	ntgo	mery	
ក្អ	RESIDENCE OF DECEDENT 10a. BTATE 10b. COUNT	Y		10c CIT	Y, TOWN OR L	OCATI	ION			-			
E	Maryland Montg	0me 2 37			kville							10d. INSIDE CITY LIMITS?	
Ţ	10e. STREET AND NUMBER	omery		ROC	KVIIIE	_	ZIP CODE			100 (1	TIZEN OF	1 X YES 2	NO
E.	4723 Bartram Str	eet				1.5	20853				S.A.	WHAI COUNTRY	
BY FUNERAL DIRECTOR	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. AR	MED	13. WAS		ENDENT OF HISPAI	NIC ORIGIN	(Specify Ve			E — American Indi	-
F	1 Never Married 2 Married	FORCES? 1	YES 2 X	10	If yo	s, spe	cify Cuban, Maxica 2 NO Specif	an, Puerto R	can, atc.)	01110	Blec	k, White, atc.	erri,
	3 Widowed 4 Divorced				. 22	120	a li no apacin		adori	an		_{"y.} alvadori	lan
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	18a. DE	CEDENT'S	USUAL OCCU	PATIO	N t of working	16b,	KIND OF BU	SINESS/IN	IOUSTRY		
E	Elementary/Secondary (0-12)	College (1-4 or 5+)	llfe.	Do NOT us	vork done durin se retired.)	y mos	i or working						
MP	N/A		N/	A (I1	nfant)			N/	A				
00	17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NA			Sumame)			
BE	Jose Salvador Fl	ores					Ermind	a Flo	res				
0	19a. INFORMANT'S NAME (Type/Print)						nd Number or Rural						
	Jose & Erminda F	lores	4	723	Bartra	m S	Street,	Rockv	ille,	Mar	ylan	d 20853	
	20a METHOD OF DISPOSITION 1 N Burial 2 Cremetion 3 Rem	oval trom State	20b. PLACE	NODATE	OF DISPOSITIO	N (Nar	ne of	DATE	20c. LO	CATION -	- City or To	own, State	
	4 Donation Donation The (Specify) Gate of Heaven Cemetery 6/16/95 Silver Spring, MD												
	21. SIGNATURE OF FUNERAL SERVICE LA	DENSEE			Era	E AN	ADDRESS OF FA	CILITY	nc Fu	nore	1 Uo:	me, P.A.	
. 8	Henry St.	0			473	Q I	Raltimor	. a . b . b . c	ns ru	nera		e, MD 20	701
	23. PART i. Enter the diseesas, or	complications that	causad tha da	ath. Do r	ot anter the	mod	la of dying, auc	h aa cardi	ac or read	iratory a	rreet.	Approxim	
N.	shock, or heart fallura.	Liat only one caus	e on each line									interval B	etween
	immediate cause (Final disease or condition resulting in dasth) s. Congestive Heart Failure Birth-Dea												
	resulting in dasth) - s. CONGESTIVE HEART FAILURE BIRTH-DEI									DEA			
_	Sequentially list conditions To VENTRAL SEPTAL DEFECT Birth-DEA									Deat			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEC	DUENCE OF		_	DOTE					CITALIA	DEA
SAT	cause. Enter UNDERLYING	Ris	SOMV		X							Birth-	Dex
Ĕ	CAUSE (Disesse or injury that initiated events	DUE TO	OR AS A CONSEC	DUENCE OF	7:							DIAM	DLI
	reaulting in daeth) LAST	d											
2	PART II. Other significant condition	a contribution to	do oth had not -					I					
EDICAL	TAIT II. Other significant condition	a contributing to t	aeth but not n	eauiting i	n the undar	lying	cause given in	Part I.	24a. WAS AN PERFOR		24b	. WERE AUTOPSY FI AMILABLE PRIOR	TO
ă								— l'	1 YES 2	NO		OF DEATH?	AUSE
Σ										ι ·		1 TES 2	NO
ä	DID TOBACCO USE CONT	RIBUTE TO CAL					UNCERTAIL	ИП					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			H (Check only OTHER:	one)							
ΥS	1 TYES 2 NO	1 Inpetient 2			4 🗆 Nursing		5 Realdence	8 🗆 Other	(Specify)				
	27. MANNER OF DEATH 1 Natural 5 Pending	28a, DATE OF I (Month, Da		28b, TIM INJ	E OF 28c	WOR	IK?	28d. DESC	RIBE HOW I	NJURY O	CURED		
BY	Accident Investigation						ES 2 NO						
	3 Suicide 8 Could not be 4 Homicide detarmined	28a. PLACE OF building, a	INJURY — At hor tc. (Specify)	ma, term, s	treat, factory,	offica		281. LOCAT	TION (Street I Town, State)	and Numbe	or Rural F	Route Number,	
E													
립	29a. CERTIFIER (Check only 1 CERTIFYING PHYSI	CIAN: To the best of r	ny knowledge, da	nth occurre	d at the time,	deta a	and place, and due	10 the caus	e(a) and mar	nner aa sti	rted.		
COMPLET	one) 2 MEDICAL EXAMINE	R: On the besie of ex	mination and/or i	nveatigatio	n, in my opinie	on, de	ath occured at the	time, deta s	nd place, en	d due to t	he ceuse(s	and manner as st	tated.
	290. SIGNATURE AND THILLIPS THE SEE	1				Т	29s. LICENSE NUN	WBER		29d. DA	TE SIGNED	(Month, Day, Year)	
BE	Show the	2					D45	115		>	1/1	1195	
입	30. NAME AND ANDRESS OF PERSON WH		DEATH (ITEN	1 27) (Type,	Print)		V 10	1.0			9/1	0/17	
I	Forbes D. Porter	7 7				e .	Bldg. 61	B. Ro	om 21	5. R	ockwi	ille, MD	
						,		-, 10	- M 1	١١ و ب	CKV	LLI COLL	
1	JUN 19 1995	Ja Danie											

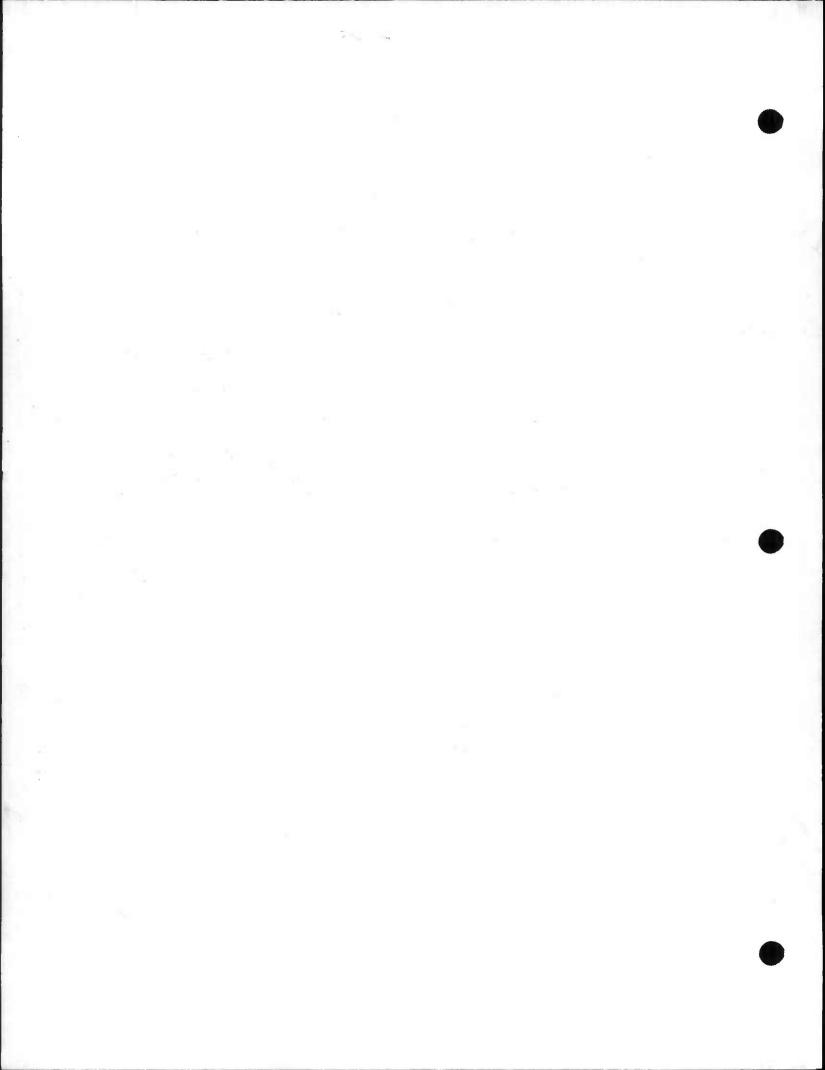


		1 - FOR STATE REGISTRAR		STATE OF MA					EALTH AND	MENTA	L HYGIEN							
		1. DECEDENT'S NAME (First,		Loui:			ote			2. DATE MONT			/EAR	TIME OF DEATH				
9		4. SOCIAL SECURITY NUMB 220-14-43	397	1 □ M 2 😡 F	. AGE (In yrs. Ia	est birthday) YRS.	IF UNDER 1	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.		OF BIRTH	8.		ACE (State or Foreign				
, 2, 3 should	DIRECTOR	98. FACILITY NAME (If not in Far)		emonial	_ Ho	spite			OR LOCATION OF D	_		BC. COUNTY	Ha Ha	TH /				
Pages 1,	JEC	10a. STATE	10b. COUNTY			10c, CIT	TY, TOWN OF						10	10d. INSIDE CITY				
		Maryland		Harford			Abero	deer	n				1	LIMITS?				
it permit.	FUNERAL	10e. STREET AND NUMBER		70 2				101	. ZIP CODE			10g. CITIZE	N OF WHA	AT COUNTRY?				
transi	NE	1541 Po	erryma				1.00.00		21001				S.A.					
21215-0020 al or attending physician. for use as the burial-transit	ВУ	1 Never Merried 2 3 Widowed 4 Divo		12. WAS DECEDENT E FORCES? 1 IF YES, GIVE WAR	YES 2 💢		H	yes, spe	ENDENT OF HISPAL ecity Cuben, Mexica NO Specif	an, Puerto I			Specify:					
r atten use as	TEO	15. DEC (Specify ont	CEDENT'S EDUC	CATION completed)	(('Give kind of v	Work done do	CUPATIC	ON est of working	16b	KIND OF BUS							
D 21	PLET	Elementary/Secondary (0)-12)	College (1-4 or 5+)	like .	fe. Do NOT us	ise retired.)		0.000									
YLAND S by the hospital be detached for at once.	COMPL	17. FATHER'S NAME (First, MI	ficidle, Leet)	6		choor	Teac	cher	18. MOTHER'S NA		Board o		cati	on				
MARYLAND retained by the hospit 5 should be detached notified at once.		James I		George							ickwort							
MARY retained b 5 should notified	TO BE	19a. INFORMANT'S NAME (7)	Type/Print)		11	9b. MAILING	ADDRESS	(Street a	and Number or Rural				ode)					
	۲	James W. I	Foote,	Sr.					n Road,					21001				
R Pa		20e. METHOD OF DISPOSITI 1 Seriel 2 Cremetio 4 Donetion 5 Other	on 3 - Remo		20b. PLACE cametery, cri Bethe	EANDDATE	OF DISPOSIT	TION (Na		DAT	20c. LO	CATION — CIT	y or Town,					
0 = 0		22. NAME AND ADDRESS OF FACILITY Tarring—Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23. PART I. Enter the disease, or complications that gaused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, Approximate																
hours or rer		IMMEDIATE CAUSE (Fin	wart lanure, L	List only one cause	on each line	10.					liac or reapl	ratory arrea	t,	Approximate Interval Between Onset and Death				
d within 24 ompletely fill, cremation, the event, the		disease or condition resulting in death)	→ ,	F) J P)	(RA71	900	PA	180	MONIA	3				ONEDAY				
	-		_		RAS A CONSE									HOURS				
8 70 2	CATION	Sequentially list conditi- if any, leading to immed			R AS A CONSE									-				
BOX ate be e hysician prior to		cause. Enter UNDERLY!	ING	-				URI	TOUS U	< C E	RS			ONE MONT				
othe plane	CERTIFI	that initiated events resulting in death) LAST		DUE TO (OR	R AS A CONSE	OUENCE OF	F):											
0. 4 8 7 8	CER			A														
E SA B	A	PART II. Other eignifice	nt condition	a contributing to de	ath but not	reaulting	In the und	derlying	cause given in	Part I.	24a. WAS AN			ERE AUTOPSY FINDINGS				
RECOR requires that een signed by of Health an shows any	MEDIC	ALZHEL	MER:	HERAL	6, 14	YPE1	2761	711	ON,	_	1 TES 2		CC	OMPLETION OF CAUSE F DEATH?				
RECO w requires th been signed to d Health shows an	W.	7.81886	PEMI	PHERAL	NAJC	VLAR	10	181						□ YES 2 □ 116				
3 ept b	PHYSICIAN:	DID TOBACCO US		LIBUTE TO CAUS					UNCERTAI	N 🗆]								
VITAL AN: The lav fificate has State Dep	SICI	EXAMINER?		HOSPITAL:			TH (Check on	:		0055								
SICIAN Certiff h the S	HYS	27. MANNER OF DEATH		1 Inpetient 2 ER	JURY	28b, TIM	E OF 2	Ing Home	e 5 🗆 Residence		(Specify)	LILIRY OCCUP	en .					
NG PHYS fter this cath with marked	ВУ Р		Pending Investigation	(Month, Day, Y	(bar)	INJ	JURY M	WOI	RK?	200.02	Office Horr	Wont Good.	IEU					
TTENDI TTOR: A after de	COMPLETED B	3 Suicide 8 G	Could not be determined	28e. PLACE OF IN building, etc.	JURY — At he (Specify)	ome, farm, s	street, factor	ry, office		281. LOCA City o	ATION (Street a or Town, State)	nd Number or	Rural Rout	e Number,				
B BB DIE	3	29e. CERTIFIER 1 CERTI	TFYING PHYSIC	CIAN: To the best of my	knowledge, d	eath occurr	ed at the tim	ne, date	end place, end due	to the cau	se(e) and man	ner se stated						
HOSPITAL FUNERAL WITHIN 72	S I			R: On the baels of exami									ause(a) en	nd menner ea stated.				
TO THE HOSPITAL TO THE FUNERAL Se filed within 72 IMPORTANT: If		296. SIGNATURE AND TITLE							29c. LICENSE NUM					onth, Day, Year)				
TO THE DE filed IMPOR	TO BE	30 NAME AND ADDRESS OF	DEDOCAL WITH			17161	'A~		D46	4/6				3 /995.				

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

HARFORD MEMORIAL HOSMAN HAVREDE GRACE

► JUNE 23 1995. 501. S. UNION AVENE



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-s hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, remailton, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE

	REGISTRAR		CERTIF	CATE OF	DEATH	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
1	Virginia	Mae	Fog	٦٥		MONTH DA	YEAR			
	4. SOCIAL SECURITY NUMBER 5. SE						24, 1995			
	The second secon	32.	n yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	6. BIF	RTHPLACE (State or Foreign untry)		
1	217-32-7459	M 2 X F	88 YRS.	months Date	moons win.	Feb.10, 1		Maryland		
	9a. FACILITY NAME (If not institution, give street an	d number)		96. CITY, TOWN	OR LOCATION OF DE		9c. COUNTY OF			
Œ	Frederick Memorial	Hospital		End	ederick					
12	RESIDENCE OF DECEDENT	Hospital		116	ederick		Frede	erick		
DIRECTOR	10a. STATE 10b. COUNTY									
<u>E</u>	Maryland Freder	2 -1-						10d. INSIDE CITY LIMITS?		
		ICK		Walkers				1 TYES 2 NO		
M	10e. STREET AND NUMBER			10	. ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?		
1 11	10101 Kelly Rd. 21793 U.S.A.									
FUNERAL	11. MARITAL STATUS 12. W	AS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Specify Yes	or No.— 14. B/	ACE — American Indian.		
	1 Never Married 2 Married FORCES? 1 YES 2 NO If yes, specify Cuban, Maxican, Puerto Rican, etc.) Black, White									
B	3 🕅 Widowed 4 🗌 Divorced	YES, GIVE WAR OR DA	ILES	1 YES	Z NO Specify		Sp	White		
	15. DECEDENT'S EDUCATION		40- 0505054550	1		1				
1 2	(Specify only highest grade comple	ited)	16a. DECEDENT'S (Give kind of w	ork done during me retired.)	ost of working	16b. KIND OF BUS	SINESS/INDUSTRY			
1 5		ege (1-4 or 5+)								
5	6		home	emaker		own	home			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Malden	Surname)			
	George T. Rippeon				Fann	ie Mae Smi	th			
BE	19a. INFORMANT'S NAME (Type/Print)		105 MAII INC	ADDRESS (Comple		Poute Number, City or Town				
2										
	Cynthia D. Brown		9221	Jak Tree	Circle	Frederi	ck, MD	21701		
	20s. METHOD OF DISPOSITION 1 A Burlal 2 Cremation 3 Ramoval in	20b.	PLACE AND DATE O	F DISPOSITION (N	ame of	DATE 20c. LO	CATION — City or	Town, Stata		
	4 Donation 5 Other (Specify)		etery, crematory or ot airmount	Cemete	rv	6/27 Li	bertyto	wn. MD		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE				ND ADDRESS OF FA	CILITY				
	D.D. Hartzler & Sons									
	atherine V.	Soull	er	Li	bertytown	ı. MD				
	23. PART i. Enter the diseeses, or compli	cetiona thet	the deeth. Do n	ot enter tha mo	de of dying, auci	ea cardiac or reepi	ratory arrest,	Approximate		
	ahock, or haert fallure. List o	nly one cause on as	ich ilne.					Interval Between		
	IMMEDIATE CAUSE (Final disease or condition	C = 110 C 0		11510	T -11	140 G		Onset and Death		
	reaulting in death) a.	CONGES			TAT	LURE.				
			CONSEQUENCE OF							
z	I I	SCHEMI	CAR	SDID W.	HTA901	4 .				
CERTIFICATION	Sequentially liet conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):						
ΙĘ	cause. Enter UNDERLYING									
E	CAUSE (Disease or injury that initieted events	DUE TO (OR AS A	CONSEQUENCE OF):						
E	resulting in death) LAST			,						
	d									
	PART II. Other eignificant conditions con-	tributing to death be	ut not recuiting i	n the underlyin	a ceuse alven in	Part I. 24s, WAS AN	ALITOPSY 2	4b. WERE AUTOPSY FINDINGS		
EDICAL	(R) LUNG MASS			, , , , , , , , , , , , , , , , , , , ,		PERFOR		AMAILABLE PRIOR TO		
ă		<u> </u>				1 🗆 YES 2	DNO	COMPLETION DF CAUSE OF DEATH?		
M	IDDM.							1 TYES 2 NO		
	DID TOBACCO USE CON	STRIBUTE TO	CAUSE OF	DEATH '	YES I NO		ľ			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		3.1000 3.		ACE OF DEATH (Chi					
5		SPITAL:	5203	OTHER:						
× S		ripallant 2 - ER/Outp			ne 5 🗆 Raaldenca					
표		(Month, Day, Year)	28b. TIME	OF 28c. IN.	JURY AT DRK?	26d. DESCRIBE HOW I	NJURY OCCURED			
BY	1 Natural 5 Pending				YES 2 NO					
	2 Sulpide	28e. PLACE OF INJURY	- At home, farm, a	treet, factory, offic		28f, LOCATION (Street a	and Number or Run	al Route Number.		
	4 Homicide detarmined	building, atc. (Speci	ify)			City or Town, State)				
COMPLETED										
4	29a. CERTIFIER (Check only	To the bast of my knowl	edge, dasth occurre	d at the time, data	and place, and due	to the cause(a) and man	iner as stated.			
S	2 MEDICAL EXAMINER: On t	the basis of axamination	and/or investigation	n, in my opinion, o	leath occured at the	tima, data and place, an	d dua to the caus	e(a) and manner as stated.		
BE	296, SIGNATURE AND TITLE OF CERTIFIER A Below MD	(0110-1	uno Ph	in strain	39c. LICENSE NUM	18ER 3	29d. DATE SIGN			
5	000000	0	-	Λ	7 0,02	0137	0	124195		
F	30. NAME AND ADDRESS OF PERSON WHO COM		TH (ITEM 27) (Type,	Phat	- A	DA 00		1380 1		
	trederick Memo	orial H	080	tred	usuele,	MD -	11/02	- 31		
1 1	31. DATE FILED (Month, Day, Year)	2. REGISTRAR'S SIGNA 2 8 1995	TURE							
		1 -	A .	. 0						
	6/20/05 111	2 8 1005	Sulsa attorno	Lanke .	11					

within Jurs after death. Page 6 may be retained by the hospital or attending physician. ppletely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should cremation, or removal. BALTIMORE, MARYLAND 21203-3146

notified at once.

traumatic event, the medical examiner must be

DAY 12146 C 0 SECODE DIVISION OF VITAL

		量	io.	
ç	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filly	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to bunal, cremation,	
DIVISION OF VITAL RECORDS, F.O. BOA 13148,	ecuted	ind cor	bunal,	
_	8	5	2	
5	ate be	ysicla	prior	
	ertific	ng ph	glene	
	ath c	ittend	tal Hy	
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3	lat	9	and	
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Ú	requ	Sen	6	
	WE G	has b	Dept.	
2	HE :N	cate	State	
>	SICIA	certif	the .	
5	PHY	this	1 with	
	DING	After	death	
2	ITEN	CTOR:	after	
2	DR/	DIRE	hours	
_	A	MAL	2	
	HOSPI	FUNE	within	
	품	표	filed	
	2	2	2	

is marked, or item 23 shows any injury, or other PHYSICIAN: MEDICAL CERTII

ВУ

COMPLETED

BE

2

IMPORTANT: It Item 28

												20	6) () (ı
	FOR STATE REGISTRAR	STATE OF M			RTMEN'					YGIENI EG. NO.	E				
	1. OECEDENT'S NAME (First, Middle	, Last)							2. DATE OF I	DEATN	v	YEAR	3. TIME C	F DEATH	
	Marian Louise							June	24	1995		5:	00 A.	М	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER		-	R 24 HRS.	7. OATE OF E (Month, Da	NATH V Year)		8. BIRTI	HPLACE (St	ate or Foreign	n
	187-30-2995	1 🗌 M 2 🔀 F	56	YRS.	MONTHS	DAYS	HOURS	MIN.	Jan. 5.				ver. E	PA.	
	Se. FACILITY NAME (If not institution	n, give street and number)			9b. CITY	, TOWN	R LOCAT	ION OF D				NTY OF C			
RO	5258 Grand Valle	u Road			Wes	stmins	ster				Car	roll			
DIRECTOR		OUNTY		100 013	ry, TOWN	20.1.004	TION!						10d. INSI	DE OITY	
#		armol1			vestmi								LIMI	TS?	
	10e. STREET AND NUMBER	alloll		1 "	vesuill		. ZIP COD	\E			10 a CIT	TEN OF	WHAT COU	2 🔀 NO	_
FUNERAL		- 17 7				101						S.A.	WHAI COO	VIRTE	
뿐	5258 Grand V	alley Road 12. WAS DECEDENT	CENTED IN ILE AD	WED.	T 40	W40 050	211		NIC ORIGIN? (S					an Indian	
교	1 Never Merried 2 Merrie	FORCES? 1	YES 2 X			If yes, sp	ecify Cubi	en, Mexico	en, Puerlo Ricar		Of MO		E — Americ k, White, at	c.	
B	3 Widowed 4 Divorced	IF YES, GIVE W	AH OH DATES			1 [YES	2 🔀 NO	Specif	y:			Whit			
요	15. OECEOENT				USUAL O				16b. KIN	D OF BUS	INESS/IN				
<u> </u>	(Specify only highest grade completed) (Give kind of work life. Do NOT use re			work done	aunng ma	IST OF WORK	ng								
릴	12 2 Lab Tech. Medicine														
COMPLETED	17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)														
ш	Curtis D. Jo	nes					Gra	<i>ac</i> e	Garrett						
8	19e. INFORMANT'S NAME (Type/Prin	nt)	191	. MAILING	G ADDRES	S (Street e	and Numbe	or or Rural	Route Number, (City or Town	n, State, Zi	ip Code)			
2	Donald E. Froc	k		5258 (Grand	Valle	ey Ro	ad, W	estminst	er, M	D. 2	?1157			
	20e. METHOD OF DISPOSITION 1 □ Burlal 2 □ Cremetion 3 □	Removel from State	20b. PLACE other pl	OF OISPO	SITION (N	ame of cer	metery, cre	matory or		20c. LO	CATION —	- City or T	own, State		
	4 Donation 5 Other (Specif		Carrol	1 Cre	matio	n. Ir	C			Hamps	stead	MD.	2107	4	
	21. SIGNATURE OF FUNERAL SERV	VICE LICENSEE					ND ADDRE			_					
	1/200	@0:			1 *		Fune				17 10		1074		
ヿ	23. PART i. Enter the disease	ea, or complications that	caused the de	eth. Do					ch aa cardiac	_				proximata	
		allure. List only one cau	sa on each line	l.			COMPANY.							erval Between and De	
- 1	iMMEDIATE CAUSE (Finei disease or condition	6	ol ore	-	-	Ca	nce	Y					2	1	
-	reauiting in death)	4.	OR AS A CONSE			6-							×	2 46.	100
_		- 30			,								İ		
-ICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSE	QUENCE C	OF):										
A	cause. Entar UNDERLYING) .													
H	CAUSE (Diseese or injury	OR AS A CONSE	DUENCE C	OFI:							-			-	

resulting in death) LAST

PART ii. Other aignificant conditions contributing to daeth but not resulting in the underlying cause given in Part I.

metastases

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 WES 2 NO 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2 NO 26. PLACE OF DEATN (Check only one) HOSPITAL OTHER 4 - Nursi 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 5 - Reeldence 8 - Other (Specify) 27. MANNER OF DEATH 28e. OATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Netural 5 Pending M 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide

29e. CERTIFIER (Check only 1 🗆 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and menner ee stated (Check only one) 2 MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(a) and manner as stated.

296. SIGNATURE AND TITLE OF CENT

30. NAME AND ADDRESS WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Arity MD.

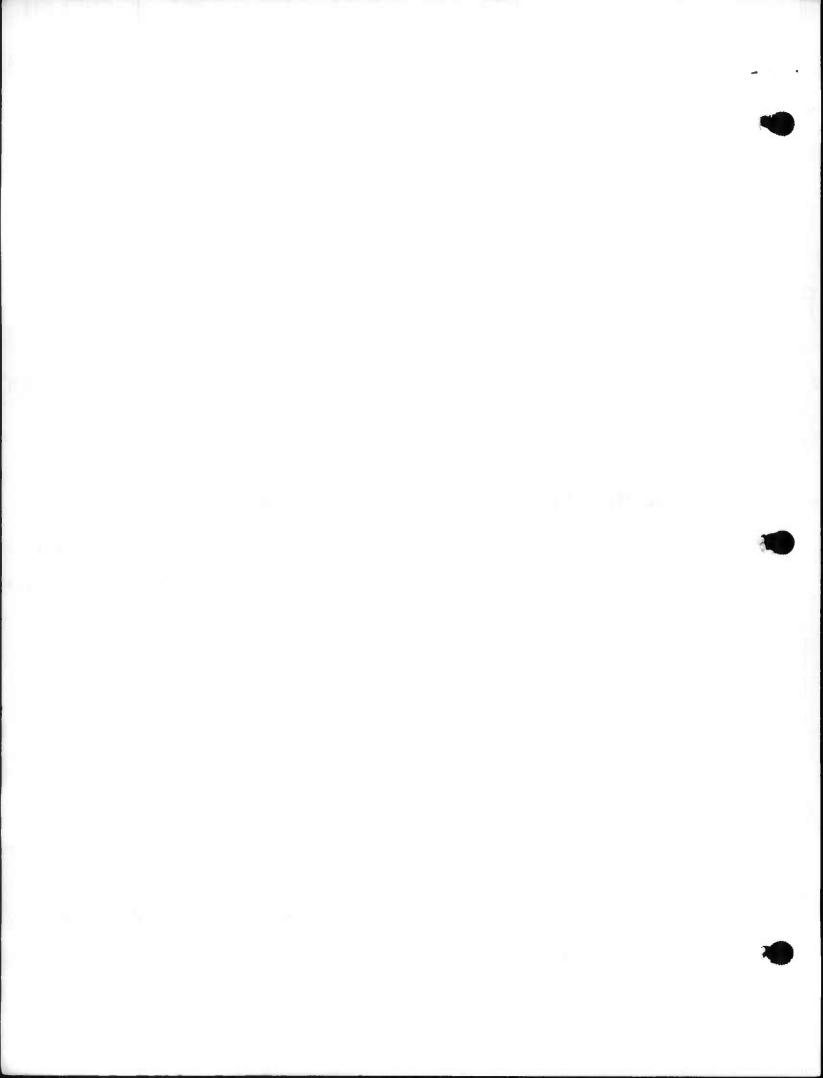
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MDU 39646

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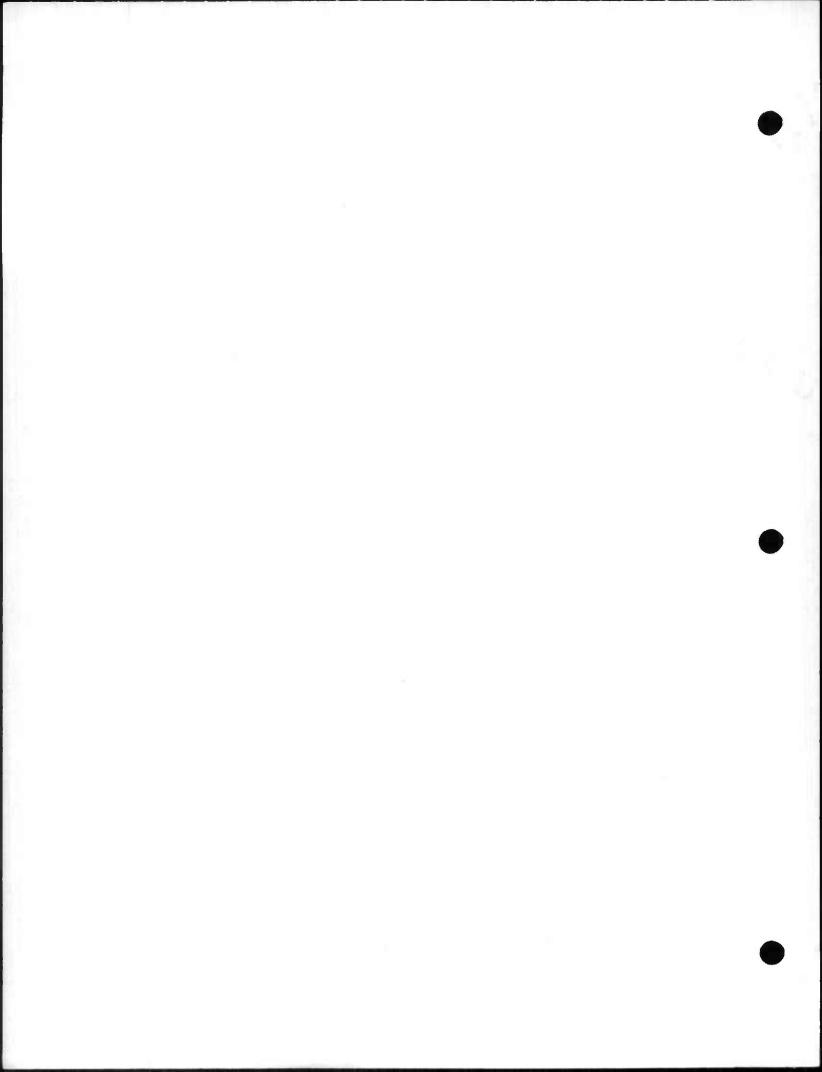
31. DATE FILEO (Month, Day, Year) 1995



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

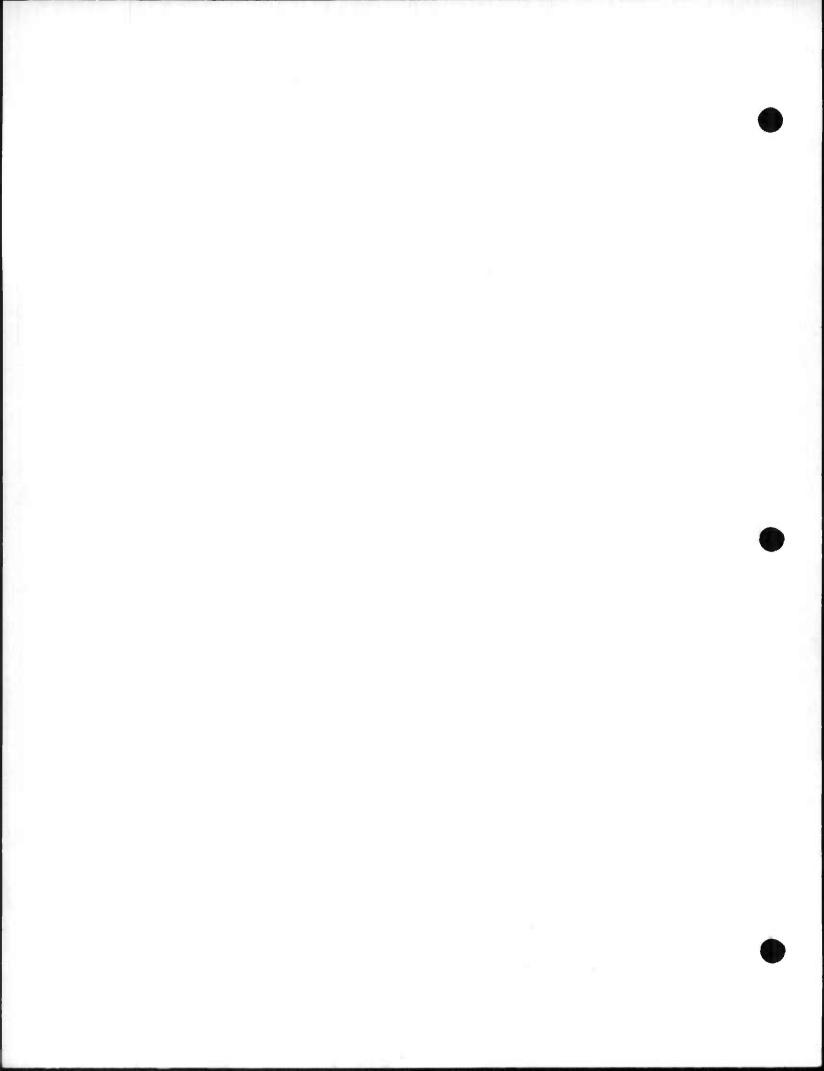
	1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTAL HYGIE			
	1. DECEDENT'S NAME (First, Middle, Last	t)				2. DATE OF DEATH	J		3. TIME OF DEATH
	DAVID AN	THONY GREEN				June 25		YEAR	0930.
	4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		. BIRTHP	LACE (State or Foreign
	578-46-4968 9e. FACILITY NAME (If not institution, give		7 YRS.	ONTHS DAYS	HOURS MIN.	July 10,			Jersey
œ			- 1		R LOCATION OF D		9c. COUNT		
DIRECTOR	Carroll County	y General Hos	pical	West	minister		Ca	rrol	1
Ĕ.	10e. STATE 10b. COUN	TY	10c. CITY,	TOWN OR LOCAT	ION				10d. INSIDE CITY
5	Maryland Ca	arroll	Mt	. Airy					LIMITS?
AL	10e. STREET AND NUMBER	ET AND NUMBER 101. ZIP CODE				10g. CITIZE		1AT COUNTRY?	
FUNERAL	5324 Pommel Dr:	ive			21771		Unit	ed S	tates
5	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specify Y	en or No- 1	4. RACE	- American Indian,
ВУ Б	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 X YES	ATES	1 TYES	2 X NO Specif	nn, Puerto Rican, etc.)		Black, Specify	White, etc.
		Coast Guard							White
COMPLETED	15. DECEDENT'S ED (Specify only highest grad	UCATION de completed)	16a. DECEDENT'S US (Give kind of wo	rk done durina mo:	N st of working	16b. KIND OF BI	USINESS/INDU	STRY	
Ä	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT use						
M	17. FATHER'S NAME (First, Middle, Last)	4	Sa1	es			Compa	ny	
		Croon				ME (First, Middle, Maide			
B	Alfred Joseph 19a. INFORMANT'S NAME (Type/Print)	Green	Torre continue			Van Arsda			
ဍ		-1 C				Route Number, City or To			
	Constance Shi			ommel D		. Airy, Ma			1771
	ABuriel 2 Cremetion 3 Ref	moval from State	o.PLACEAND DATE OF ine Grove	DISPOSITION (Na or place)		1	OCATION — CI		
	21. SIGNATURE OF FUNERAL SERVICE L		The Grove		D ADDRESS OF FA	/28/95 Mt			
- ()	$\langle \chi \rangle = 1$	7		22. NAME AN	D ADDRESS OF FA	Stauffe	er Fune	eral	Homes, P.A
_1	/ Jamy of	(Javrey C	2	8 Eas	t Ridgev	ille Blvd.	Mt.	Airy	, MD 21771
Z	IMMEDIATE CAUSE (Final disease or condition resulting in death)	Complications that ceuse. List only one cases on a	ech iine.			ial		, q	Approximate interval Between Onset and Daath
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		CONSEQUENCE OF):		V				
MEDICAL	- 31	depu	ssio	n_		PERFO	RMED?	6	YERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO
SICIAN	DID TOBACCO USE CONT	IRIBUTE TO/CAUSE C			UNCERTAIL	V 🗆			
ਹੁੰ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	(Check only one)					
IYS	1 YES 2 NO	1 □ Inpatient 2 □ ER/Outs	petient 3 DODA 4	☐ Nursing Home		8 Other (Specify)			
PHY	1 Natural 5 Pending	(Month, Day, Year)	28b. TIME (ry wo	RK?	28d. DEŞCRIBE HOW	INJURY OCCU	RED	
à	2 Accident Investigation	28a. PLACE OF INJURY	/ At home form of	M 1 🗆 Y	ES 2 NO				
TED	3 Suicide 8 Could not be 4 Homicide determined	building, atc. (Spec	city)	pet, factory, office		261. LOCATION (Street City or Town, State	and Number or	Rural Rou	rte Number,
COMPLETED		SICIAN: To the beat of my know IER: On the beals of examination							and manner as stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIE	n 43 a	Lutz		29c. LICENSE NUM	48ER 9 2	29d. DATE S	IIGNED (A	fonth, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WI	BAR	F 11	int)	NEV	vni	wds	BR	md,
	31. Dayte FILED (Month, Day, Year) JUN 2 6 199	32. REGISTRAR'S SIGN	Lar Rodell						



DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Panes 1 2 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
HE HOSPITAL OR A	HE FUNERAL DIRE	ed within 72 hours	
2	10	De file	-

		FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART			MENTAL HYGIE		
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH	DAY Y	3. TIME OF DEATN
		Marjorie					June 2	25 199	95 4:45 A M
		215-42-7982			F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Sept. 21,]	005	BIRTNPLACE (State or Foreign Country)
		9a. FACILITY NAME (If not institution, give st	27		b. CITY, TOWN C	OR LOCATION OF D		9c. COUNTY	Maryland
Ì	OR	Laurelwood Nursin	g Home		I	Elkton			Cecil
	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	TION			10d. INSIDE CITY
		Maryland	Cecil		(Conowing	0		LIMITS?
	FUNERAL	10e. STREET AND NUMBER 10f. ZIP CODE						10g. CITIZER	N OF WHAT COUNTRY?
- 1	W	467 Rock Spring R		ULI O ADMED	T 10 100 200		918		U.S.A.
		1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR D.	2 NO	If yes, spe	ecity Cuban, Mexic	NIC ORIGIN? (Specify Y an, Puerto Rican, etc.)	es or No- 14.	. RACE — American Indian, Black, White, etc.
	D BY	3 📉 Widowed 4 🗌 Divorced		AIEO	1 TES	2 NO Specif	ny:		Specify: White
	LETEI	15. DECEDENT'S EDUC (Specify only highest grade	completed)	16a. DECEDENT'S US (Give kind of work life. Do NOT use r	k done during mo:	ON st of working	16b. KIND OF B	USINESS/INDUS	TRY
	P	Elementary/Secondary (0-12) Three Years	College (1-4 or 5 +)		emaker				
once.	COMP	17. FATHER'S NAME (First, Middle, Last)		11011	CIICICE	18. MOTNER'S NA	AME (First, Middle, Maide	on Surname)	
7	BE (e Alexander				Cora R		
otifie	2	190. INFORMANT'S NAME (Type/Print) Betty Lou Bulgin					Route Number, City or To		
Pe l		20a, METHOD OF DISPOSITION	200	PLACE AND DATE OF				.ngo, Ma .ocation – city	aryland 21918
Hest		1 ☐ Buriel 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State Cem	Hopewell	Ceme te				osit, Maryland
liner	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Lee A. Patterson & Son Funeral								
ехап		Thomas	mratte	raso de	Perryy	ville. Ma	son & Son aryland 2	Funera) 1903	L Home
event, the medical examiner must be notified		23. PART I. Entar the diseases, or complications that caused the death. Do not antar tha mode of diving, such as cerdiec or respiratory street, shock, or haert fellure. List only equa ceuse on eech line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):							Interval Between
or other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):					
any	EDICAL	PART II. Other significant conditions	contributing to death b	ut not rasulting in	the undarlying	cause given in		N AUTOPSY DRMED? 2 NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
2	Σ ∦	DID TOPACCO HEE CONTR	IDLITE TO CALICE O	F DEATH VEC					1 TES 2 NO
23	AN	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL		F DEATH YES		UNCERTAI	иЦ		
or item	SICI	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Outp.	0	THER!	5 Residence	6 Other (Specify)		
	PHX	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b, TIME O	F 28c. INJU	URY AT	28d. DESCRIBE HOW	INJURY OCCUR	ED
T .	8	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆 Y	ES 2 NO			
28 is	ETED	3 Suicide 8 Could not be 4 Nomicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, stre ify)	et, factory, office		281. LOCATION (Street City or Town, State		Rural Route Number,
릗	COMPLI		IAN: To the bast of my knowl : On the basis of examination						suse(s) and manner as stated,
ORTA	BEC	296. SIGNATURE AND TITLE OF CERTIFIER	1 1			29c. LICENSE NUI	WBER	29d. DATE SI	GNED (Month, Day, Year)
IM	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE					-	125/95
		Joseph G. Lanzi, M	.D., 721 Bri	dge Stree		on, Mary	land 219	21	
		31-DATE FILED (Month, Day, Joan) JUN 27 1995	32. REGISTRAR'S SIGN	artall					

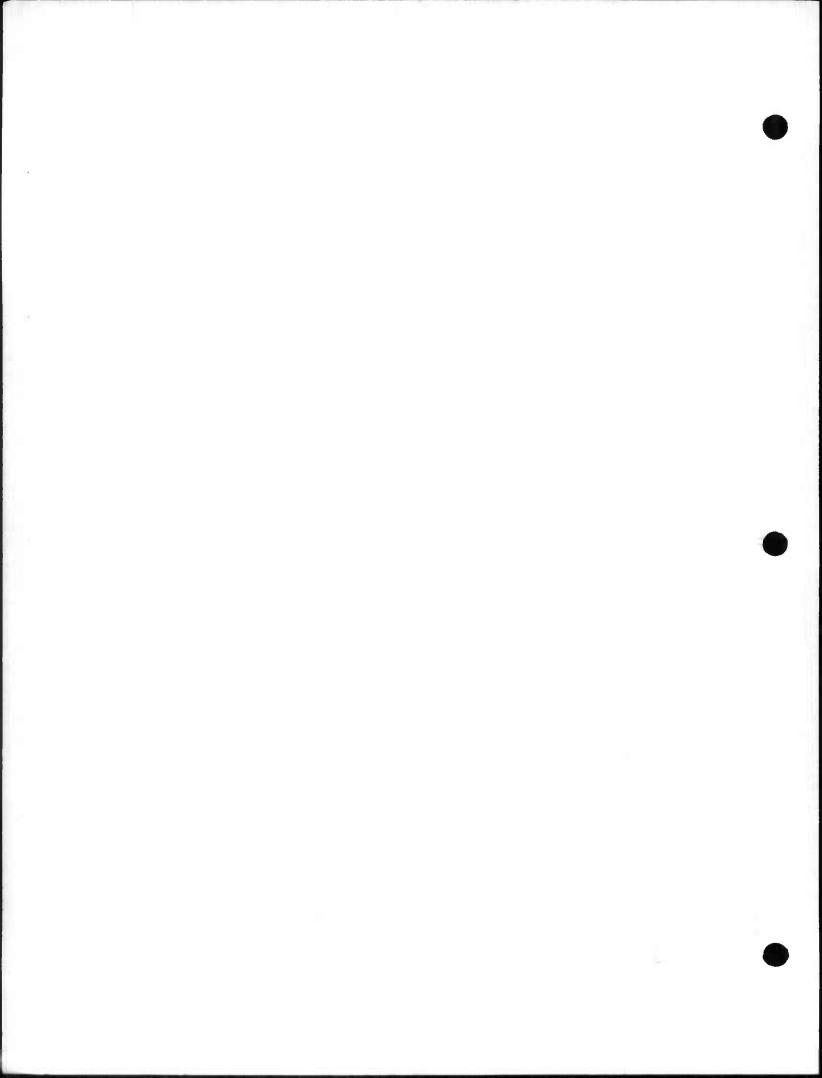


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DIVISION OF VITAL RECORDS, P.O. BO)

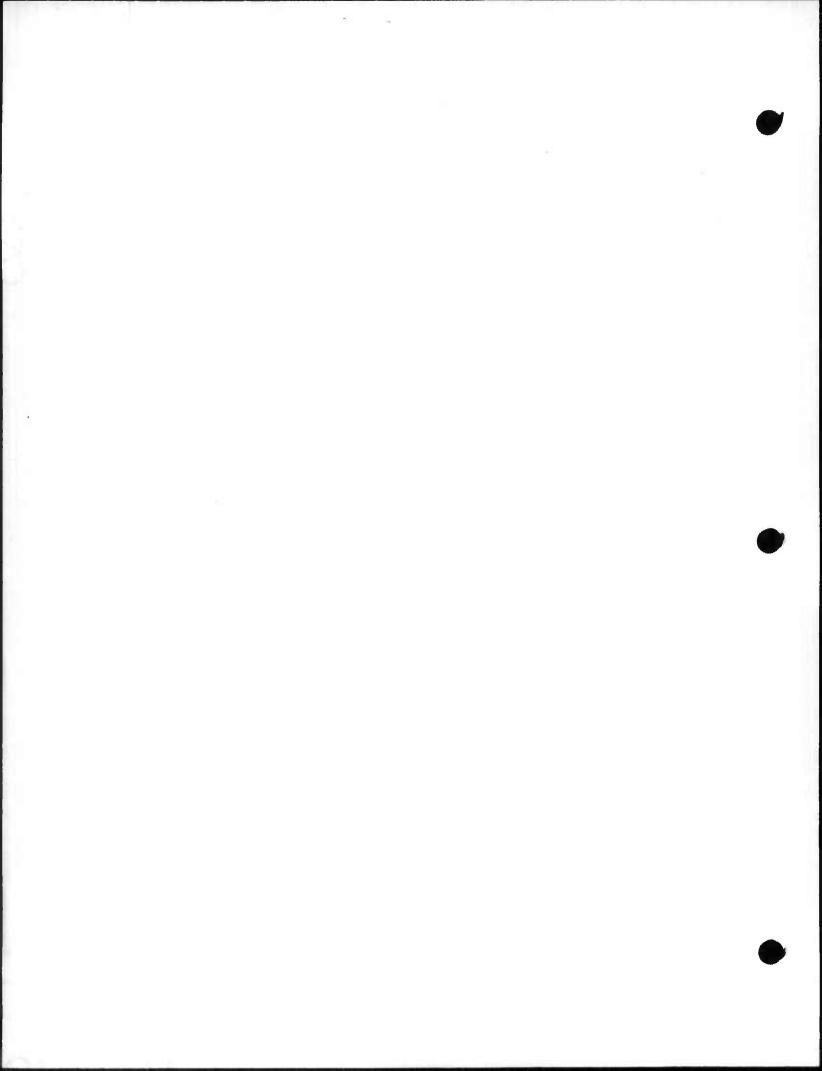
s after death. Page 6 may be retained by the hospital or attending physician.	by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should immoral	lical examiner must be notified at once.	
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be made after the form with the State Dest of Health and Mental Horisene notor to burial remarking or named.	IMPORTANT: If Nem 28 is marked, or Nem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	Control of the contro

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM	MENT OF H	EALTH AND N	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	KATHERINE	ELOISE	GLAUDE				, 1995	YEAR 1:00p M
	4. SOCIAL SECURITY NUMBER		aec	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)
	579-05-0273	1 □ M 2 X X 77	YRS.	- CATE	HOURS WITE.	Feb. 13,	1918C	harlottesvII
œ	9a. FACILITY NAME (If not institution, give s	·	10	27. 4	R LOCATION OF DE		9c, COUNT	Y OF DEATH
DIRECTOR	8100 Conn. Ave		C	HEVY c	chase, mo	ā	Mont	gomery
Ä	10e. STATE 10b. COUNT			OWN OR LOCATI				10d. INSIDE CITY LIMITS?
		gomery	Chev	y Chas	se			1XXYES 2 NO
FUNERAL	10e. STREET AND NUMBER				ZIP CODE	-	10g. CITIZE	EN OF WHAT COUNTRY?
8100 Conn.Ave. Chevy Chase, Md. 20815 U.S.A.								
	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	If yes, spe	city Cuben, Mexicen		or No 1	4. RACE — American Indien, Black, White, etc.
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES	1 TYES	2XXIIO Specify:			Brack
COMPLETED	15. DECEOENT'S EDU (Specify only highest grade	CATION COMPLETE	16a. DECEDENT'S US	UAL OCCUPATION	N .	16b. KIND OF BU	SINESS/INDU	STRY
	Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work		t or working	n a a a a a	1 0	
MP		5t	Gov, t W	crker				ernment
	17. FATNER'S NAME (First, Middle, Last)					IE (First, Middle, Meiden	Sumeme)	
BE	J. Francis Tayl 190. INFORMANT'S NAME (Type/Print)	or	10b MAII INC AC	DDESC (Street or	Eva Gil	LMET oute Number, City or Tow	A	
5	Celia Vance					-	n, State, Zip C	(ode)
20a. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of						7	CATION — CI	ty or Town, State
	1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	cem	etery, crematory or other	place) emeter	v e			land,Md.
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE		22. NAME AND	D ADDRESS OF FAC	ILITY		
	Welliam F.V	nagrude	Λ.,	W1111	am F.Ma	agruder l	Funer	al Home Ave,S.E.
	23. PART I. Enter the diseases, or	complications that caused	tha death. Do not	antar the mod	le of dying, auch	as cardiec or respi	ratory arres	et, Approximata
	IMMEDIATE CAUSE (Final	List only one cause on e	ach line.	1 1				Interval Between Onset and Death
	disease or condition resulting in death)	av	ocard	ial 1	nfor	Lion		
		DUE TO (OR AS	CONSEQUENCE OF					
NO	Sequentially list conditiona,	b. DUE TO JOB AS A	CONSEQUENCE OF:	4570				
CERTIFICATION	if sny, leading to immediate cause. Enter UNDERLYING	/ /	regriseducine org					
띮	CAUSE (Disesse or injury that initiated events	C. OUE TO (OR AS A	CONSEQUENCE OF):					
FF	resulting in death) LAST	d						
2	PART II. Other significant condition	as contributing to deeth h	ut not resulting in t	he underlylag	cause shop in E	art I. 24s. WAS AN	41770704	24b. WERE AUTOPSY FINDINGS
S			at the todating if t	ne underlying	Cadec given in F	PERFOR	MEO?	AMAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC						1 YES 2	×2Nο	OF DEATH?
						-		1 NES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			26. PL/	ACE OF DEATN (Chec	ck only one)	-	
VSIC	1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outp	atient 3 DOA 4	THER: Nursing Home	5 N Residence 6	☐ Other (Specify)		
PH	27. MANNER OF DEATN	26e. OATE OF INJURY (Month, Day, Year)	28b. TIME O	F 28c. INJU WOR		28d. OEŞCRIBE HOW II	NJURY OCCU	RED
ВУ	1 Netural 5 Pending 2 Accident Investigation			M 1 TY	ES 2 NO			
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, tarm, street/l/y)	nt, factory, office		261. LOCATION (Street e City or Town, State)	and Number or	Rural Route Number,
Ш	29e. CERTIFIER			-				
COMPLETED	(Check only 1 CERTIFYING PNYS	ICIAN: To the best of my know						
	296. SIGNATURE AND TITLE OF CERTIFIES		and/or investigation, is					ceuse(e) end manner ee stated.
BE	and sharkfully and title of Genthel	// //	/		29c. LICENSE NUME	DER	29d. DATE S	SIGNEO (Month; Day, Year)
5	30. NAME AND ADDRESS OF PERSON WAS	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Nos. Pro	4)	0/2/	6	6	117/95
	Chinistaglia	- Anko	10 2111	's L	5+ 11.	WASHE	2	200 200
	31. DATE FILED (Month, Day, 1944)	32. REGISTRAR'S SIGN	ATURE		pa	WITZITL	1	4002:1
	JUN 2 0 1995 8	Tulia Davidson Ras	dall					



BALLIMORE, MARTLAND	nours after death. Page 6 may be retained by the hosp	d in by the funeral director, page 5 should be detached	or nemoval.	medical examiner must be notified at once.	
CHISTON OF ALL AL MECONDS, T.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely ment in by the funeral director, page 5 should be detached	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or manneral,	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

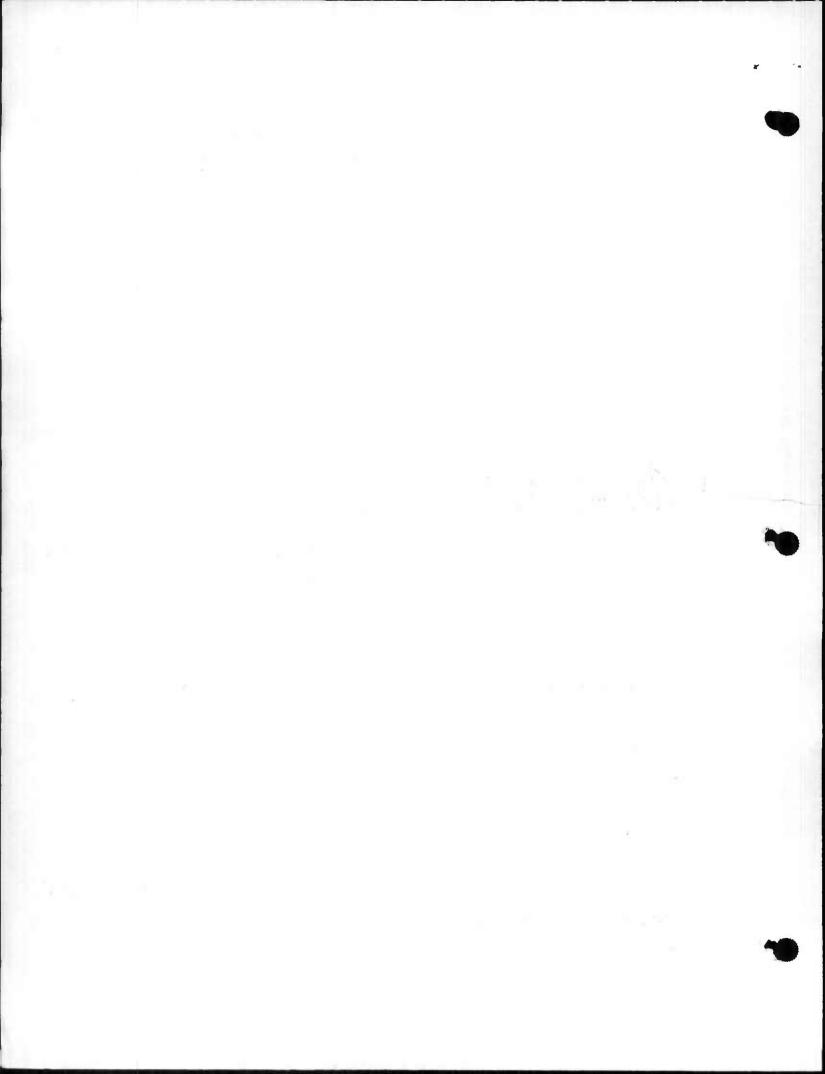
	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last)			7.11 E 01	DEATH	2. DATE OF DEATH		3.	. TIME OF DEAT	н
	EARL STAUFFER	GOTTSHALL,	JR.				, 199 ⁵	EAR	9:50	Ам
	4. SOCIAL SECURITY NUMBER 5	S. SEX 6. AGE (II	n yrs. lest birthday) F	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)			ACE (Stelle or Fo	
		M 2 □ F 69	YRS.	NTHS DAYS	HOURS MIN.	Feb. 6, 1	1926		Jersey	
or.	9a. FACILITY NAME (If not institution, give stree		98	. CITY, TOWN (R LOCATION OF D	EATH	9c. COUNTY	OF DEA	тн	
DIRECTOR	Fallston General 1	Hospital		Fal	lston		Har	ford	d	
REC	10a. STATE 10b. COUNTY		10c. CITY, T	OWN OR LOCAT	ION			10	d. INSIDE CITY	
		arford	E	el Air				1	LIMITS?	NO
FUNERAL	100. STREET AND NUMBER	Tot. 21P CODE					10g. CITIZE	N OF WHA	T COUNTRY?	
NES	116 West Heather 1				2101			USA		
FU	11. MARITAL STATUS 1:	2. WAS DECEDENT EVER IN FORCES? 1 ∑ YES	2 NO	13. WAS DEC	ENDENT OF HISPAI colfy Cuban, Mexico	NIC ORIGIN? (Specify Yes	s or No- 14	RACE Black, V	American India Vhita, etc.	n,
ВУ	3 Wildowed 4 Divorced	1953 - 195		1 TYES	2X NO Specif	y:		Specify:	White	
ED	15. DECEDENT'S EDUCAT (Specify only highest grade cor	ION	18a. DECEDENT'S USI	JAL OCCUPATION)N	18b. KIND OF BU	SINESS/INDUS		71111100	-
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work life. Do NOT use re							
MP		5+	Chemical	Engin			Govern	ment	-	
	17. FATHER'S NAME (First, Middle, Last) Earl Stauffer Go	ottshall, S	lan.			ME (First, Middle, Malden				
B	19a. INFORMANT'S NAME (Type/Print)	occident, S	Sr.	DDEGG (Standard	Lorai	ne W				
2	Virginia G. Gottsh	nall				Bel Air,				
	20a. METHOD OF DISPOSITION	20h	PLACEANDDATEOFD				CATION — CITY		State	
1 Burlel 2 Cremetton 3 Removal from State 4 Donatton 8 Other (Specify) R.A. Ferris & Co. 6-27+95 W										
	21. SIGNATURE OF UNENAL BERVICE INCEN	SEE	777	22. NAME AN	D ADDRESS OF FA	CILITY				\neg
	1 X/11/90	Jana?		Howard	K. McC	omas III F y Rd., Abi	uneral	Hon	e, P.A	.
	23. PART I Enter the diseases, or con	nplications that caused	the deeth. Do not	enter the mo	de of dying, auc	h as cardiec or reap	nggon, iratory errea	MO.	Approxima	ita
	snocit, or neert failure. Lia	it only one ceuse on ee	ch line.						Interval Be Onset and	tween
	Metastatic prostate cancer to liver Metastatic prostate cancer to liver Due to (or as a consequence of): pancieae bone and intra abdominal one to									
	Due to (or as a consequence of): Dance to part of the transfer of the transfe									
NO	Sequentially list conditione, If any leading to immediate b. Due to (or As A consequence of): The fact facts The fact fact facts The fact fact facts The fact fact facts The fact fact facts The fact fact facts The fact fact fact facts The fact fact fact facts The fact fact fact fact fact fact fact fact									
¥	Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING Cause. Enter UNDERLYING CALLSE (Please or lating) CALLSE (Please or lating)									
필	CAUSE (Disease or Injury that Initiated eventa resulting in deeth) LAST Malignant plenal Effusion Malignant plenal Effusion years years years Cachesia.						4			
CERTIFICATION	resulting in deeth) LAST	Senere	malig	rant	· Cac	hesia.				
	PART II. Other eignificent conditione of	contributing to death bu	t not requiting in t				ALITOREY	T 0.05 MM	ERE AUTOPSY FIR	-
CAL	colon polyps	- questo	ratte c	ancer	couse given in	PERFOR	RMED?	AM	MILABLE PRIOR 1	то
MEDIC	thistory of 1	uper tens			•	1 🗌 YES 2	CHO	Of	F DEATH?	2.5
2	DID TOBACCO USE CONTRIB				UNCERTAI	VI I			tapph	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	2	6. PLACE OF DEATH (OTTOLINIAL			///	1 -45/5-0	2030
SIC		OSPITAL:		THER: Nursing Home	5 🗆 Rasidence	6 Other (Specify)				
E	27, MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF			28d. DESCRIBE HOW I	NJURY OCCUR	ED		\neg
В	1 Natural 5 Pending 2 Accident Investigation	NOT APP	LICABLE	M 1 🗆 Y	ES 2 NO					
<u>a</u>	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY - building, atc. (Specif	At home, ferm, atree	t, factory, office		28f. LOCATION (Street a City or Town, State)	and Number or I	Rural Rout	e Number,	
<u>-</u>										
COMPLET	(Check only CERTIFYING PHYSICIA	N: To the best of my knowle								
		On the basis of axamination	and/or investigation, in	i my opinion, di						
B	296. SIGNATURE AND TITLE OF CERTIFIER	e. o . M	D		D 44	248	29d. DATE SI	IGNED (M	onth, Day, Year)	395
2	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, Prin	11) ()	1 1	, 3	- 024	110 1	-0 -	7,5
	MUTHULAKSHM			POTO	MAC P	HYSICIAN	5 104	+ PL	UMTRE	G
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	TURE	Ro	AD BE	ELAIR MA	RYLA	ND	21014	$\overline{}$
JUNBJUNG 8/1995 This Muchan Ranhill							-/-//		7	



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DIVISION OF VITAL RECORDS, T.O. DOX 13149,	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with? with the mospital or attending by the hospital or attending physician.	TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the further filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT, If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

1. DECEDENT'S		t, Middle, Last) Lee	Groves							2. DATE O MONTH JUN		AY 16	YEAR 195	3. TIME OF DEATH
4. SOCIAL SEC				. AGE (In yrs. las	t birthday)	IF UNDER	1 1 YEAR	IF UNDER	24 HRS.	7. DATE OF	F BIRTH	~ /		PLACE (State or Foreign
235-20			1 □ M 2 🖔 F	73	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month,	Day, Year)	921	Countr	
			street end number)			9b. CITY		OR LOCATIO		EATH			ITY OF D	
327: RESIDENCE 100. STATE Mary 1a: 100. STREET A 327: 11. MARITAL S		es Rd.					Wo	odbi	ne			I	lowa:	rd
10e. STATE		10b. COUNT	Y		10c. CIT	Y, TOWN	OR LOCAT	TION						10d. INSIDE CITY LIMITS?
Mary1a:	nd		Howard			Wo	odbi	ne						1 TES 2 NO
10e. STREET A	ND NUMBER	1	-				101	. ZIP CODI	E			10g. CITI	ZEN OF V	VHAT COUNTRY?
327		es Rd.							1797				U.S	
11. MARITAL S		Married	12. WAS DECEDENT I	YES 2 AR	MED		If yes, sp	ecity Cube	n, Mexica	NIC ORIGIN? In, Puerto Ric		or No-	14. RACE Black	— American Indien, c, While, atc.
3 Wildowed Elementary 1:7. FATHER'S N			IF YES, GIVE WAF	OR DATES			1 TYES	2 (X) NO	Specif	y:			Speci	White
		CEDENT'S EDU		16e. DE	CEDENT'S	USUAL O	CCUPATIO	ON nat of worldr	207	16b. I	CIND OF BU	SINESS/IND	USTRY	
Elementary	/Secondary		College (1-4 or 6+)		ive kind of v Do NOT us									own
1			4		teacl	ner/	home	· · · · · · · · · · · · · · · · · · ·			_	lic s	scho	ol/ home
17. FATHER'S N										ME (First, Mi				
James							17771115-			11a A			- 11.5	
19a. INFORMA										Route Numbe			,	
		Groves								dbine				1.12.74
	Cremati	on 3 🗆 Rem	noval from State	20b. PLACE other pl	ece)				natory or		4.7	CATION —		
4 Donation			omer / /	Pipe	Cree	2K U	NAME A	ery ND ADDRE	99 OF F4	CILITY -	Inr.	New	win	dsor, MD
10	than	· O.	Santa	len						dsor,		rtzle	er &	Sons
IMMEDIATE disease or o resulting in	CAUSE (F		a. DUE TO (0			HEA	ms	FA	nue	E				Interval Betwee
Sequentially if eny, leadi			b. J DUE TO (O	R AS A CONSE R AS A CONSE R AS A CONSE R AS A CONSE	OUENCE O	EARI PI:		12038	EK6					YEARS
cause, Enta CAUSE (Dis that Initiate resulting in	ease Dr Inj d events	ury	c. DUE TO (O	DIANSE	OUENCE O	M F):	ELL	In.	S					YEARS
		-	d											
PART II. OII			na contributing to d		reaulting	In the u	nderlyin	g causs	given in		PERFO	RMED?	240	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 MO
25. WAS CASE EXAMINER	R?	TO MEDICAL	HOSPITAL:	SIN SPORT		OTHE	R:			heck only one				
1 TYES			1 Inpetient 2 I		_	4 🗆 Nu	raing Hor		esidence	6 🗆 Other				
27. MANNER C	el 6	Pending Investigation	28e. DATE OF IN (Month, Day)		26b. TIN	IE OF JURY M	W	JURY AT ORK? YES 2 [] NO	28d. DE\$0	CRIBE HOW	INJURY OC	CURED	
3 Sulek	de 6	Could not be determined	28e. PLACE OF building, et		ome, farm,	street, fac	ctory, offic	Ce			TION (Street Town, State		r or Rural	Route Number,
29e. CERTIFIE (Check on one)	y I DE CE		ER: On the basis of exa											e) end manner es stated.
29b. SIGNATU	RE AND TITL	E OF CERTIFIE	7/					29c. LIC	ENSE NU	IMBER		29d. DAT	E SIGNE	(Month, Day, Year)
296. SIGNATU	Ene	151	u					10	25	947		50	INE	23, 1995
30. NAME AND	AODRESS	OF PERSON W	HO COMPLETED CAUSE	OF DEATH (ITE	40 T	Frint)	DAK	s Ro	, ,	MRK	VILES			2,029
31. DATE FILE			32. REGISTRAD	S SIGNATURE										
JUN	2 8 19	15 Ju	of the state of	and the										



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	FOR	STATE OF MARYLA	IND / DEE	DADTMENT	UE NE	CALTH AND A	ACNTAL LIVELEN				
	1 - STATE REGISTRAR	STATE UP MARTLA		IFICATE			REG. NO.	_			
	1. DECEDENT'S NAME (First, Middle, Last)		3.				2. DATE OF DEATH MONTH DA		YEAR	. TIME OF DEATH	
	Madeline Nove						June 21	199	5	1:00 B M	
	4. SOCIAL SECURITY NUMBER		n yrs. last birtho	MONTHS		#F UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		Country)	ACE (State or Foreign	
	213 46 9157 9e. FACILITY NAME (If not institution, give str	1 M 2 X 8 8 C)		TOWAL OF	R LOCATION OF DE	06/03/1		Mary of DEAT	yland	
Œ							AIR	Charles			
6	Post Office B	OX 201				town					
DIRECTOR	10a. STATE 10b. COUNTY		1	. CITY, TOWN O						od. INSIDE CITY LIMITS?	
1 1								10a CITI		X YES 2 NO AT COUNTRY?	
FUNERAL				20617		11.00		States			
S	Post Office Box 207 20617 United 3								- American Indian, White, etc.		
р Вү	Blac								ck		
E	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)								*		
급	12th	College (1-4 or 5+)	Home	emakei	r		Domes	tic			
COMPLET	17. FATHER'S NAME (First, Middle, Last)	*				18. MOTHER'S NAI	ME (First, Middle, Malden				
BE	George	Farme	er			Franc	ces		Butle	er	
2	19a, INFORMANT'S NAME (Type/Print)						loute Number, City or Tow				
	Theresa Chase	I am				ve. Wa.	ldorf, M		0601 City or Town	0.4	
	1 Buriel 2 Cremation 3 Ramo	well from State	other place)				1				
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	Mary	22.	NAME AN	D ADDRESS OF FAC	rery I BL	yanı	OWII,	Maryland	
	* Lloyd 7	n. Estin					ral Home				
	23. PART I. Enter the diseases, or c	omplications that caused	I the death.	Do not enter	Agua the mod	le of dying, suci	ad Agua h as cardlec or resp	Iratory an	MD rest,	20608 Approximate	
	ahock, wheart failure. I	List only one cause on e	ech ilne.							Interval Between Onset and Death	
	diseese or condition resulting in desth)	MYDOA	rasal	TA	TI	wet _				Hrs	
		DUE TO (OR AS A	CONSEQUEN	CE OF):		1	Wor	1		11/00	
N N	Sequentielly list conditions,	DUE TO (OR AS A	CONSEQUEN	10/12 CE OF):	CA	rasov AS	WIM	0156	2003 6	773	
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Ĕ	CAUSE (Diseese or injury that initiated events	DUE TO (OR AS A									
ш	resulting in death) LAST	. Dunbe	Jes							Ton	
2	PART II. Other significant condition	a contributing to death b	ut not result	ting in the ur	nderlying	cause given in	Part i. 24a, WAS AN			VERE AUTOPSY FINDINGS	
MEDICAL							1 YES :		C	WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
¥							_	/	1	☐ YES 2 ☐ NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHE	R:	ACE OF DEATH (Ch					
HYS	1 YES 2 7NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Outp		. TIME OF	28c. INJU		8 Other (Specify) 28d. DESCRIBE HOW	INJURY OC	CURED		
	1 Netural 5 Pending	(Month, Day, Year)		INJURY M	1 _ Y	RK? 'ES 2 NO					
ED BY	3 Suicide 6 Could not be	28e. PLACE OF INJURY building, etc. (Spec	— At home, fi	arm, street, fac	tory, office		28f. LOCATION (Street City or Town, State		r or Rural Roo	ute Number,	
ETE	4 Homicide determined										
OMPLET	(Check only	CIAN: To the best of my know									
Š	2 MEDICAL EXAMINE	R: On the basis of examination	n and/or Invest	tigation, in my	opinion, de	eath occured at the	time, data and place, a	nd due to t	he cause(s) s	and manner as stated.	

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. APGISTRAPIS SIGNATURE PARTALL

STATE	0F	MARYLAND	11	DEPARTMEN	T OF	-	EALTH	AND	MENTAL	HYGIENE
			Œ	RTIFICAT	E O	F	DEAT	ГН		REG. NO.

	1. OECEDENT'S NAME (Firs	t, Middle, Last)		11				1 2. D	ATE OF DEATH		1 3	. TIME OF DEATH
	LOUIS		RRETT	HEO	/ Nic	K		y .	ONTH D		YEAR 94	757
	4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (In yrs	s. lest birthday)	IF UNDER 1 YE	EAR IF UNDER	24 HRS. 7. D	ATE OF BIRTH			ACE State or Forei
	212-28-833	9	1 😡 M 2 🗆 F	64	YRS.	MONTHS D	AY8 HOURS		forth, Day, Year)	30	Max.	vland
	9a. FACILITY NAME (If not i		treet and number)	04		9b. CITY, TO	WN OR LOCATION		15 17 912		TY OF DEA	
H	110 N. Bee	chwood	Avenue			Cat	onsvil	10		RA	151	MORE
CTOR	RESIDENCE OF DE	CEDENT						16		1 200	21	MICKE
#	10e. STATE	10b. COUNTY	Y		10c. CIT	Y, TOWN OR L	OCATION				1	0d. INSIDE CITY LIMITS?
0	Maryland		imore		Ca	tonsvi	11e				1	YES 2 NO
IAL	10e. STREET AND NUMBER	t					10f. ZIP COD	E		10g. CITIZ	EN OF WH	AT COUNTRY?
ER	110 N. Bee	chwood	Avenue				21	228		Uni	ted	States
FUN	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S				OF HISPANIC OR	IGIN? (Specify Yes	s or No—		- American Indian, White, etc.
ВУ	1 Never Married 2 3 Widowed 4 Div			MAR OR DATES		1 🗆	YES 2 NO		rto riican, etc.)		Specify:	
	Α.				Korea							White
ETED	(Specify on	CEDENT'S EDUC hly highest grade		16a	(Give kind of a life. Do NOT us	work done durin	IPATION ng most of workir	ng	16b. KIND OF BU	SINESS/INDU	JSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5	+)				100	77	1 .	0	
COMPL	1.7 FATHER'S NAME (First, I	All de la constant			Manage	er				king	Comp	any
_			ala Con						st, Middle, Maiden			
BE	William P.		ck Sr.						lice Ga			
2	190. INFORMANT'S NAME (.1						lumber, City or Tow			
	William P.		ck Jr.					t Balti	more, M			
	20a. METHOO OF DISPOSIT	ion 3 🗆 Reme	oval from State		CE AND OATE		ON (Name of			CATION — C	ity or Town	n, State
	4 Donation 6 Othe					sh Cre	matory		4 La	urel.	MD	
	21. SIGNATURE OF FUNERA	AL SERVICE LIC	CENSEE					SS OF FACILITY				
			Λ.	,		Ua-	TOTAL LI T.T.	1 ナットへ し	in a wal	Homo	Ten	
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BE COMPLETED BY PHYSICIAN: MEDICAL	23. PART I. Enter the ahock, or IMMEDIATE CAUSE (Fidisesse or condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) CAUSE (Disease or injuthet initiated eventa resulting in death) LAST PART II. Other algoritic CAUSE (Disease or injuthet initiated eventa resulting in death) LAST PART II. Other algoritic CAUSE (Disease or injuthet initiated eventa resulting in death) LAST PART II. Other algoritic CAUSE (Disease or injuthet initiated eventa resulting in death) LAST PART II. Other algoritic CAUSE (Disease or injuthet initiated eventa resulting in death) LAST PART III. Other algoritic CAUSE (Disease or injuthet initiated eventa resulting in death) LAST PART III. Other algoritic CAUSE (Disease or injuthet initiated eventa resulting in death) LAST PART III. Other algoritic CAUSE (Disease or injuthet initiated eventa resulting in death) LAST PART III. Other algoritic CAUSE (Disease or injuthet initiated eventa resulting in death) LAST PART III. Other algoritic CAUSE (Disease or injuthet initiated eventa resulting in death) LAST PART III. Other algoritic CAUSE (Disease or injuthet initiated eventa resulting in death) LAST PART III. Other algoritic CAUSE (Disease or injuthet initiated eventa resulting in death) LAST PART III. Other algoritic CAUSE (Disease or injuthet initiated eventa resulting in death) LAST PART III. Other algoritic CAUSE (Disease or injuthet initiated eventa resulting in death) LAST PART III. Other algoritic CAUSE (Disease or injuthet initiated eventa resulting in death) LAST PART III. Other algoritic CAUSE (Disease or injuthet initiated eventa resulting in death) LAST PART III. Other algoritic CAUSE (Disease or injuthet initiated eventa resulting in death) LAST PART III. Other algoritic CAUSE (Disease or injuthet initiated eventa resulting in death) LAST PART III. Other algoritic CAUSE (Disease or injuthet initiated eventa resulting in death) LAST PART III. Other algoritic CAUSE (Disease or injuthet initiated eventa resulting	disease, or cheart failure. In the condition of the condi	DUE TO B. DUE TO B. DUE TO C. OUE TO d	of coursed the use on each of correction of	Inc. INSEQUENCE OF THE ACT OF TH	411 not enter the	2 Old e mode of dy	GOLumbing, such as of the such as of	A Pike Dardiac or reap 2 Se VLR 24a. WAS AN PERFOI 1 VES 2 Y One) Dither (Specify) DESCRIBE HOW I Course(a) and ma	AUTOPSY RMED? 2 ELNO INJURY OCCU and Number of	24b. V 24b. V 24b. V 1 URED or Rural Rock d.	Approximate interval Bett Onset and E onse

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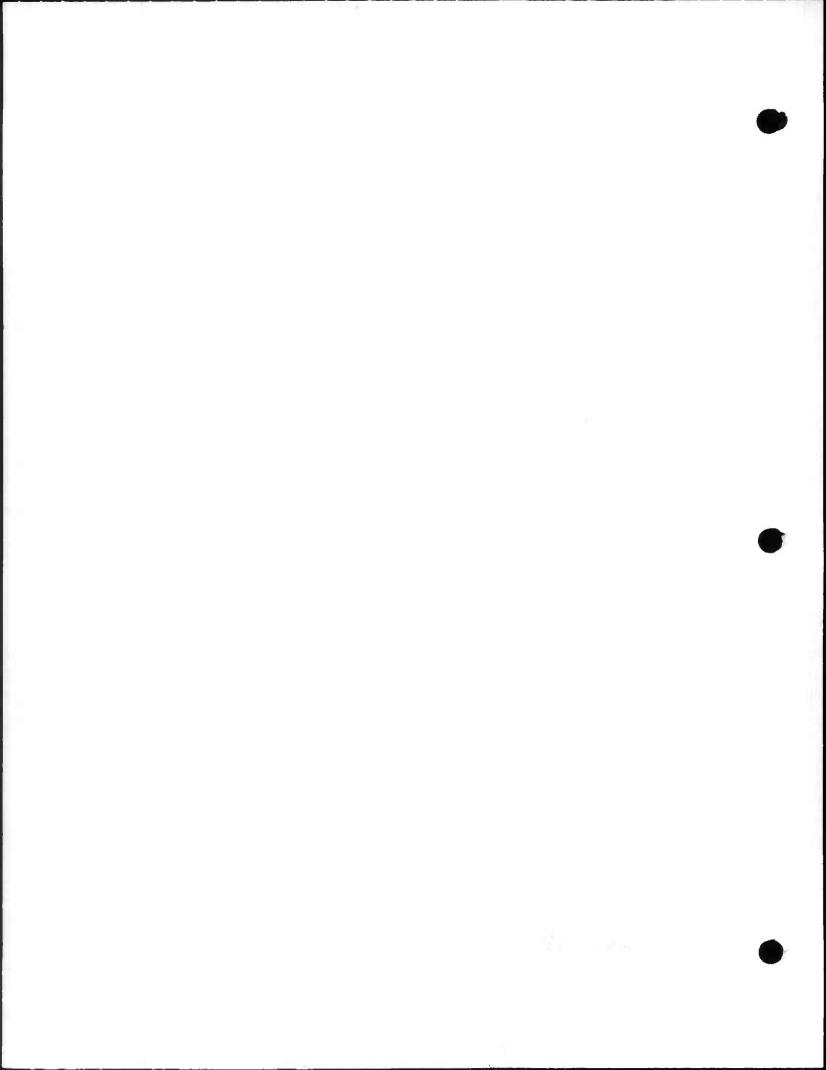
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the found the death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND		MENT OF I		MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last) James	Randolph	HARMON	N SR		June 23,	1 1995 1	3. TIME OF DEATH 1:00 AM M
	217-30-5900	6. AGE (In yrs. In	YRS.	F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH AUG. 31, 1	8.1	BIRTHPLACE (State or Foreign Country) 1rginia
TOR	99. FACILITY NAME (If not institution, give street 4104 Araby Church RESIDENCE OF DECEDENT		9	Frede	rick	EATH	9c. COUNTY Fre	of DEATH derick
DIRECTOR	Maryland Freder	rick	Frede	rown on Loca erick	TION			10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	4104 Araby Church				1701		U.S.	OF WHAT COUNTRY? A.
BY	11. MARITAL STATUS	2. WAS DECEDENT EVER IN U.S. A FORCES? 1 2 YES 2 1 1 YES 2 1 YES 2 1 YES 2 1 YES 1 Y	1954	if yes, ap	ENDENT OF HISPAI ecity Cuben, Mexica 2 NO Specifi	IC ORIGIN? (Specify Yes in, Puerto Rican, atc.)		RACE — American Indian, Black, White, atc. Specify: White
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 166. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refired.) Farmer 166. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refired.) Dairy							
BE COM	17. FATHER'S NAME (First, Middle, Lest) Charles Randolg					ME (First, Middle, Meiden ine Stewar	Sumame)	S
TO B	190. INFORMANT'S NAME (Type/Print) Mrs. Ruby A. Harmo	on 2	95. MAILING AE 4104 AY	aby Ch	urch Roa	d, Frederi	n, State, Zip Coo .ck, Ma	ryland 21701
	20e, METHOD OF DISPOSITION 1 M Burlel 2 Cremetion 3 Remova 4 Donation 5 Other (Specify)	at trom State comatery, or Resth	AND DATE OF I	place) orial Ga	ndens, Jun	e 26, 1995	cation — city Frederic	or Town, State k, Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICEN	Draf MOO2		Keene 106 E	ast Chur	sford P.A. ch St., Fr	ederic	k. Md. 21701
	IMMEDIATE CAUSE (Final	METASTATIC	LUN			h as cardiac or respi	ratory arrest,	Approximate interval Between Onset and Desth
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events	DUE TO (OR AS A CONSE	EOUENCE OF):					
	resulting in deeth) LAST							
PHYSICIAN: MEDICAL	PART II. Other aignificant conditions of	contributing to death but not	resulting in 1	he underlyin	g cause given in	Part i. 24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
AN: M	DID TOBACCO USE CONTRIE			NO C	UNCERTAIN	VIX.		1 TES 2 NO
YSIC	1 YES 2 NO	OSPtTAL: Inpatient 2 ER/Outpatient	0	THER:	8 A Residence	8 Other (Specify)		
ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME O	M 1 🗆	RK? 'ES 2 NO	26d. DESCRIBE HOW I	JURY OCCURE	D
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At he building, etc. (Specify)	ome, term, atre-	et, factory, offic	·	281. LOCATION (Street a City or Town, State)	and Number or R	ural Route Number,
COMPLETED		N: To the best of my knowledge, d						use(e) and menner so stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIED	Hondy Slo	med		29c. LICENSE NUN			e 23, 1995
10	30. NAME AND ADDRESS OF PERSON WHO C Dr. Brian M. O'Con							
	31. DATE FILED (Month, Day, Year) JUN 2 6 1995	32. REGISTRAR'S SIGNATURE	Revolates			,		



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, MARYLAND 2121	ath. Page 6 may be retained by the hospital or attr
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Σ	Page
BALTIMORE	nours after death.
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60,	Will
O. BUX 58/60.	certificate be executed with
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o.	certifi

DIVISION OF VITAL RECORDS,

DR ATTENDING PHYSICIAN: The law

After I

DIRECTOR: An hours after desitem 28 is n

TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTL DE filed within 72 hours at IMPORTANT: It item 2

permit. Pages 1, 2, 3 should the burial-transit 38 use 10 detached once. at at notified pe must t director, examiner funeral completely filled in by the medical cremation, or the traumatic event, n and cont to burial, physician prior other attending 0 Mental signed by the a Health and Men shows any 6 Dept. 23 has item certificate by the State 10 the

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CERTIFICATION

MEDICAL

PHYSICIAN:

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marked, with this

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH June 23, 1995 YEAR Barbara Jean Hurley 7:00 AM A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign (Month, Day, Year) Sept. 19, 219-52-1406 1 M 2 X F Maryland 1949 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH Frederick Memorial Hospital DIRECTOR Frederick Frederick RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY TOWN OR LOCATION 10d. INSIDE CITY Maryland Frederick Thurmont 1 YES 2 NO FUNERAL 10e STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 5020 Foxville Road 21788 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES XXNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE - American Indian, Black, White, atc. If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2XXNO Specify: 1 Never Married 2 Merried Specify: 3 Widowed 4 Divorced White 16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION pecify only highest grade comple 16b. KIND OF BUSINESS/INDUSTRY (Spe (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) Nurse Nursing Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Harry Russell Hessong Frances Margerite Fuss 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Hurley, Sr. 5020 Foxville Road Smithsburg, MD 21783 20e. METHOD OF DISPOSITION
1 □ Burlel 2 N Cremetion 3 □ Removal from State DATE 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of Hagerstown Crematory 4 Donation 5 Other (Specify) 6/24/95 Hagerstown, Maryland 22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Homes, P.A. 21. SIGNATURE OF SIMPERAL SERVICE LICENSEE 1621 Opossumtown Pike Frederick, MD Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cerdiec or respiratory street, shock, or heart failure. List only one cause on each line. Approximste Interval Between IMMEDIATE CAUSE (Finsi Onset and Desth disesse or condition METASTATIC BREAST CANCER 2 YEARS reaulting in deeth) DUE TO (OR AS A CONSEQUENCE OF) Sequentielly list conditions. DUE TO (OR AS A CONSEQUENCE OF): if eny, lesding to immediate csuse. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in deeth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS PERFORMED? AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL

26. PLACE OF DEATH (Check only one) **EXAMINER?** 1 WES 2 NO HOSPITAL OTHER: Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 1 Natural 28c, INJURY AT WORK? 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 5 Pending 1 YES 2 NO Investigation Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide

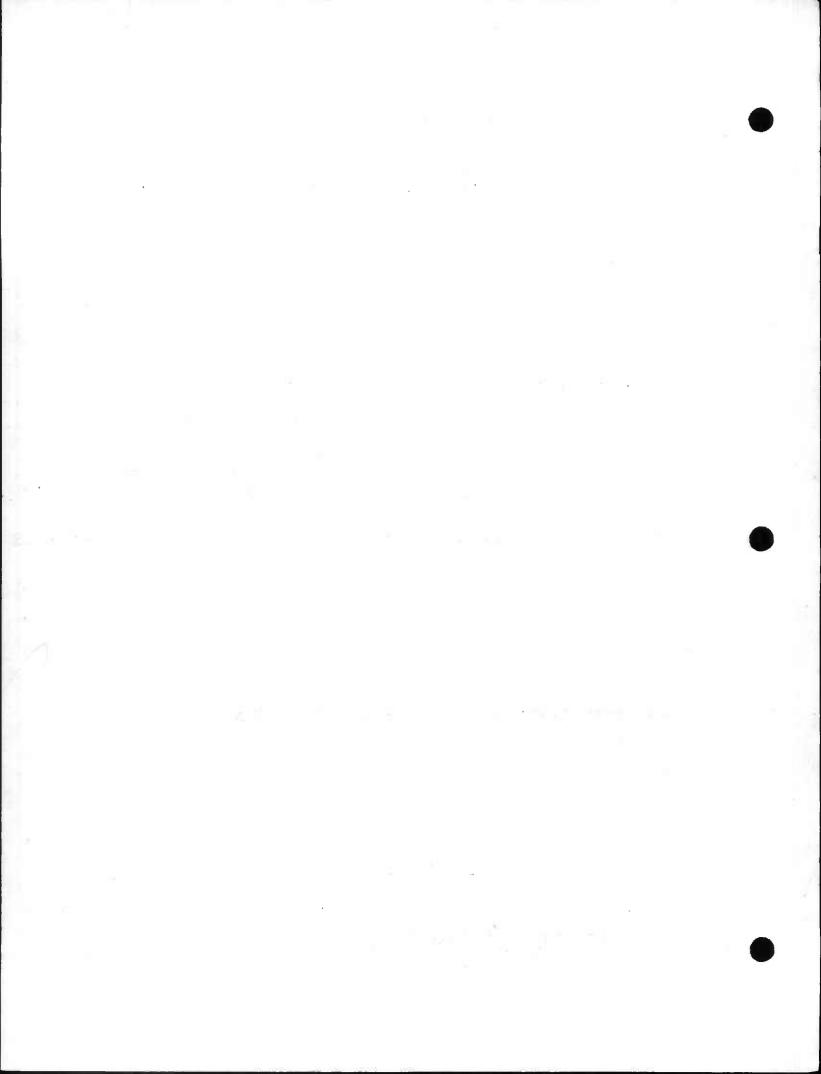
29e. CERTIFIER (Check only 1) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and manner as stated. (Check only one)

2 MEDICAL EXAMINER: On the beels of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and manner as stated 00

29b. SIGNATURE AND TITLE OF CERTIFIER	B	pallelono	an	29c. LICENSE NUMBER D 3/761	29d. DATE SIGNED (Month, Day, Year) 6 2 3 95

30. NAME AND ADDRESS OF PERSON WHO LUMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Allowar MO an. Dal M

BRIAN M	,010	ONNAR MD	581 W.	SEVENTH	ST.	FRENERK MD	21701
31. DATE FILED (Month, Day, Year) JUN 2 6	1995	32. REGISTRAR'S SIGNATURE	Rarlatte			,	



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within exchours after death. Page 6 may be retained by the hospital or attending physician.

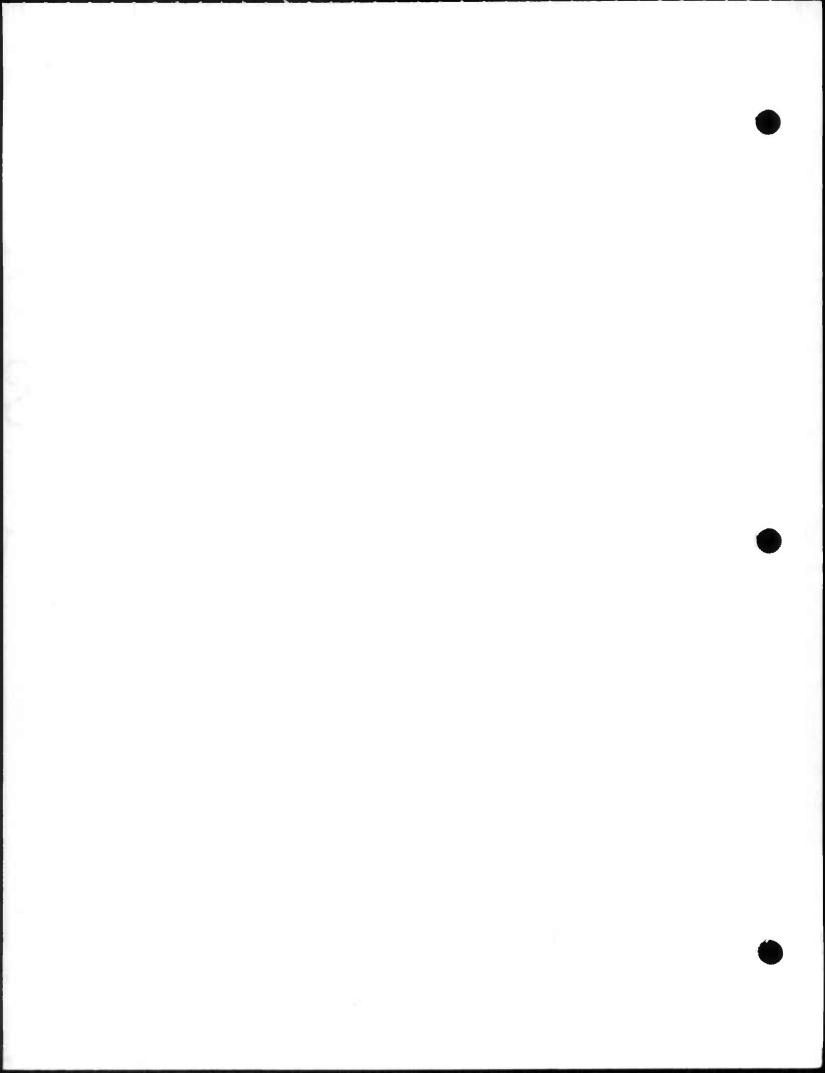
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IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be neitfied at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

						10/11	_ 01	PEA		ned. NC	٠.			
	1. DECEDENT'S NAME (First, A Orvil		onard I	HOLTZ						June 21,	1 995	YEAR	3. TIME OF DEATH 2:00 AM M	
	4. SOCIAL SECURITY NUMBER	R 5.	. SEX	6. AGE (In yrs. les	t birthdev)	JE UNDE	R 1 YEAR	IF UNDER	24 HBS	7. DATE OF BIRTH		4 BIDTH	PLACE (State or Foreign	
	214-10-4336		M 2 □ F	90	YRS.	MONTHS	DAYS	HOURS	MIN.	0ct. 17, 1	904	Countr	land	
œ	9e. FACILITY NAME (If not insti			a .				OR LOCATI	ON OF DE	ATH	-	NTY OF D		
DIRECTOR	Frederick		n Care	Center		Fr	edei	rick			Fre	deri	ck	
E I		106. COUNTY			10c. CIT	Y, TOWN	OR LOCA	TION		10d. INSIDE				
	Maryland 100, STREET AND NUMBER	Fre	derick								LIMITS? 1 YES 2 NO			
FUNERAL	4816 Old Na	itional	Pike				10		702			S.A.		
	11. MARITAL STATUS 1 Never Married 2 X M			T EVER IN U.S. AR		13.	WAS DEC	ENDENT C	OF HISPAN	IIC ORIGIN? (Specify Yen, Puerto Rican, etc.)	s or No—	14. RACE Biack	— American Indian,	
B	3 Widowed 4 Divorce		IF YES, GIVE WAR OR DATES 1 □ YES 2 X NO Specify: Specify: Wh						White					
COMPLETED	15. DECEC (Specify only fr	DENT'S EDUCAT	ION npleted)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working (Me. Do NOT use retired.)										
9	Elementary/Secondary (0-1)		College (1-4 or 5)		1000				Sagner	Ja	Tna		
₩	/			Pre	ssin	g Su	perv					IIIC.		
	17. FATHER'S NAME (First, Mide	John	Α.	HOL	ጥን			18. MOT	_	ME (First, Middle, Maiden		A D CIT	(A)T	
띪	19e. INFORMANT'S NAME (Typ)		Α.						Ber			ARSH	MAN	
٥	Mrs. Carmen	D. Hol	tz							e, Frederi			1702	
	20e. METHOD OF DISPOSITION 1 M Burial 2 □ Cremation	3 - Removal	from State	20b. PLACE / cemetery, cre					T	DATE 20c. LC	CATION —	City or To	wn, State	
	4 ☐ Donation 5 ☐ Other (S		REF	Mount	Z101			ry,		24, 1995	Lagi	espu	rg, rib	
,	100				700					sford P.A	. Fun	era1	Home	
	Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 2170 23. PART I. Enter the diseases, or complications the ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate													
	shock, or hea iMMEDIATE CAUSE (Final disease or condition recuiting in death)	rt feilure. Liai	Myc	se on each ilne	AL						iratory an	reat,	Approximate interval Between Onset and Death Hours	
_				OR AS A CONSECUTION									Vesse	
	Sequentially list condition if any, leading to immedia		B	OR AS A CONSEC									Years Years	
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury	G	DIA	BETES									Years	
	that initiated events resulting in death) LAST		DUE TO	OR AS A CONSEC	DUENCE OF	ጉ :								
	resulting in destri/ EAST	d												
- 11	PART ii. Other eignificent	conditione c	ontributing to	deeth but not r	eaulting i	in the u	nderiying	ceuse (jiven in	Part 1. 24a. WAS AN		24b.	WERE AUTOPSY FINDINGS	
DICAL	ALZHEIM	1ERS								PERFOI			AVAILABLE PRIOR TO COMPLETION DF CAUSE	
W W													OF DEATH? 1 YES 2 NO	
ž	DID TOBACCO USI	E CONTRIB	UTE TO CA	USE OF DEA	TH YE	s 🗆	NO [UNC	ERTAIN	VE				
8	25. WAS CASE REFERRED TO I	_	000.74	28. PLAC	E OF DEAT									
	1 - YES 2 - NO		OSPITAL:	ER/Outpatient 3	□ DOA	OTHE Nu		e 5 🗆 Re	aldence	6 Other (Specify)				
PHYSICIAN:	27. MANNER OF DEATH		28e. DATE OF (Month, Di		26b. TIM INJ	E OF URY	28c. INJ WO	URY AT RK?		28d. DESCRIBE HOW	NJURY OC	CURED		
À		nding restigation				M		YES 2 [NO					
- 01		uid not be	28e. PLACE Of building,	F INJURY — Al hor etc. (Specify)	me, farm, s	street, fac	tory, offic			281. LOCATION (Street City or Town, State)	and Number	or Rural A	oute Number,	
<u></u>		termined												
COMPLETED										to the cause(e) end ma			[a]	
<u> </u>			PRI The basis of ex	emination end/or i	nvestigatio	n, in my	opinion, d	eath occur	ed at the	time, date and place, ar	d due to th	e ceuse(e)	end menner ee stated.	
# 	296. SIGNATURE AND TITLE OF	F CERTIFIER							NSE NUM		29d. DAT	E SIGNED	(Month, Day, Year)	
<u>-</u>	DE NAME AND ADDRESS OF P	EDRON A	OMBI STEP OFF	P OF DEST				D 4	4309	1	J	une 2	22, 1995	
		10						E	toot	ole MJ 01	701			
	Dr. Saeed A	v. Laid	32. REGISTRA	RESIGNATURE	nous	se A	ve.,	гге	uer1	ck, Md. 21	101			
	31. DATE FILED (Month, Day Ye	1995	Jelia	RIE SIGNATURE	arbill									
1						1								



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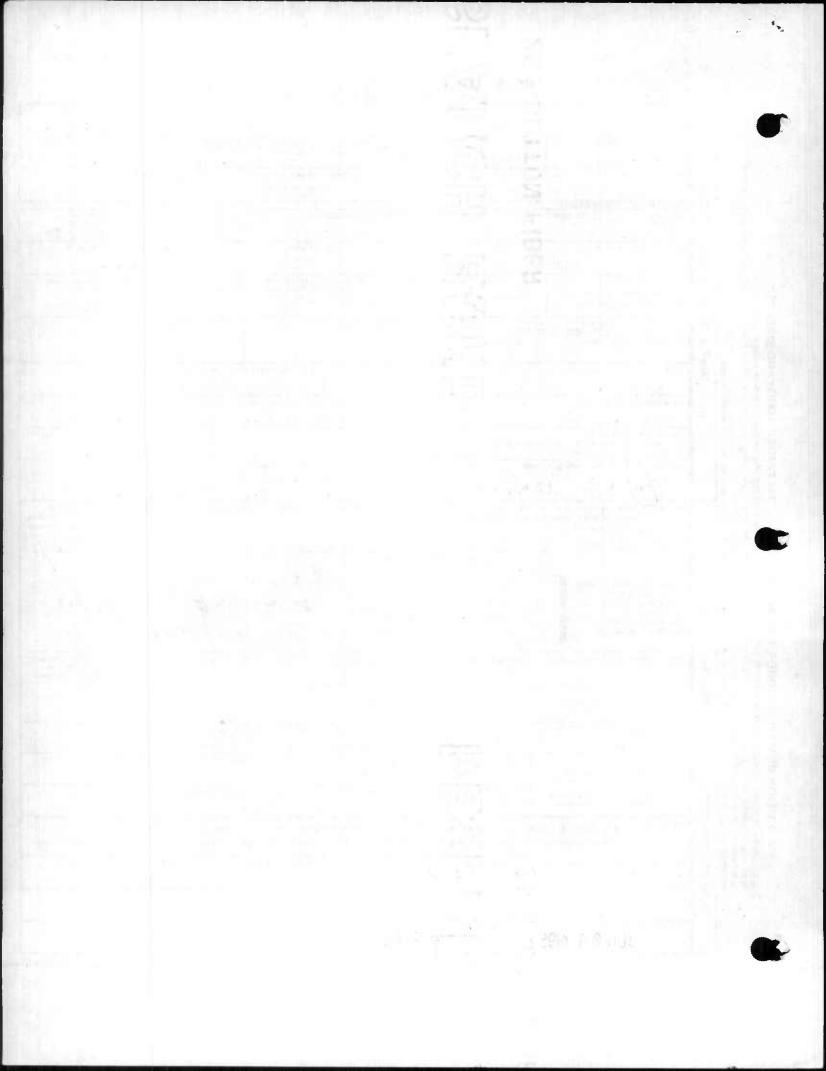
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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH			3. TIME OF DEATH
	Maxine Blake	Hammond							June 20,	1995	YEAR	12:05 P. M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDE	R t YEAR		R 24 HRS.	7. DATE OF BIRTH		8. BIRTHE	PLACE (State or Foreign
	002-30-6463	1 - M 2 -XF	84	YRS.	MONTAS	DAYS	HOURS	MIN.	Feb. 5, 1	.911	Mas	
00	9a. FACILITY NAME (If not institution, give				9b. CIT			IDN OF DI		9c. COU	NTY OF DE	
<u> </u>	Citizens Nursing	nome			Frederick					Frederick		
DIRECTOR	100 STATE 10b. COUNT	Υ		10c. CI	ry, town	OR LOCA	TION			10d. INSIDE CIT LIMITS?		
	Hampshire				Bra	dfor	d					1 YES 2 XNO
RAL	10e. STREET AND NUMBER	nt View	n d			10	1. ZIP COE			1		HAT COUNTRY?
FUNERAL	11. MARITAL STATUS	11L VIEW		ADMED	1.00		032				U.S.A	
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	FDRCES?		NO	13.	If yes, sp	ecify Cub	en, Mexica Specifi	NIC ORIGIN? (Specify Yearn, Puerte Ricen, atc.)	- American Indian, White, atc. Thite		
ED	15. DECEDENT'S EDU (Specify only highest grade	ICATION completed)	16a.	DECEDENT'S	Work done	CCUPATI during me	ON ost of work	ina	16b. KIND OF BU	SINESS/INI	DUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5	+)	staff	ise retired.)				20170	nana	~	
MP	17, FATHER'S NAME (First, Middle, Last)	7	5	Statt	MLT	rer	40.000		ME (First, Middle, Maiden	pape	L	
	Edmond P. Blake								lay Barbour			
) BE	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRES	S (Street)			Route Number, City or Tow		p Code)	
2	Nancy H. Isaacso	n	4 1	6642	Burk	itts	vill	e Rd	., Middlet	own,	Md.	21769
	20a. METHOD OF DISPOSITION 1 Duriel 2XX Cremation 3 Ram	novel from State	20b. PLA	CEAND DATE	OF DISPO	SITION (N	ame of				City or Tow	
	4 Donation 5 Other (Specify)	CENSEE		nsbur				SS OF FA		tnsb	urg,	Md.
	Who A A	2005			D	ona1	d B.	Tho	mpson Fune			
	23. PART I. Enter the diseases, or	NAME -	4 d 46	4 30 8	3	1 E.	Mai	n St	., Middlet	own,	Md.	21769
	ahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Some to	use on each l	Ine.	100	uu	eced					Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a DUE TO	C.D	SEQUENCE OF	he his	LON DON	LA SOS	lux	Level - Beart A	aftle	Pouflig re	14 3g
EDICAL CE	PART II. Other aignificant condition	ns contributing to	death but no	ot resulting	in the u	nderlyin	cause	given in	PERFO	IMED?		WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE
MED									1 □ YES 1	C NO		OF DEATH?
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL			OTHE		LACE OF	DEATH (Ch	eck only one)	_		
PHYSICIAN:	1 ☐ YES 3 (§ NO 27. MANNES-OF DEATH	1 inputient 2 i		3 DOA 266 TH	4 D Mu	rsing Hon		esidence	8 🗀 Other (Specify)	an areas and		
BY PF	1 Netural 5 Pending 2 Accident Investigation	(Month, I	Day, Mear)	104	M	1 🗆	YES 2	NO.	28d. DESCRIBE HOW I	NAURY OC	CURED	AZZ
	3 Suicide 6 Coyd5 not be 4 Hismicide defermined	284. PLACE (building	of INJURY — Ar , etc. (Specify)	home, farm,	street, fec	tary, offic	00		281. LOCATION (Street City or Town, State)	and Numbe	r or Hunel Po	oute Number
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYS								to the cause(a) and mar time, data and place, ar			and manner as stated.
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIE	OTher	eco y	1			29c. 110	ENSE NUI	409	29d. DA1	TE SIGNED	(Month, Day, Year) 20, 1995
	30. NAME AND ADDRESS OF PERSON WI					040	ما داد	Mal	21 701	0		
	Dr. B. O. Thoma 31. DATE FILED (Month, Day, Year)	32. REMISTRA	AR'S SIGNATUR	AVE.	, rr	euer	TCK,	rid.	21701			
	JUN 2 6 199	5 Julia	ARY SIGNATUR	Mardel	61							



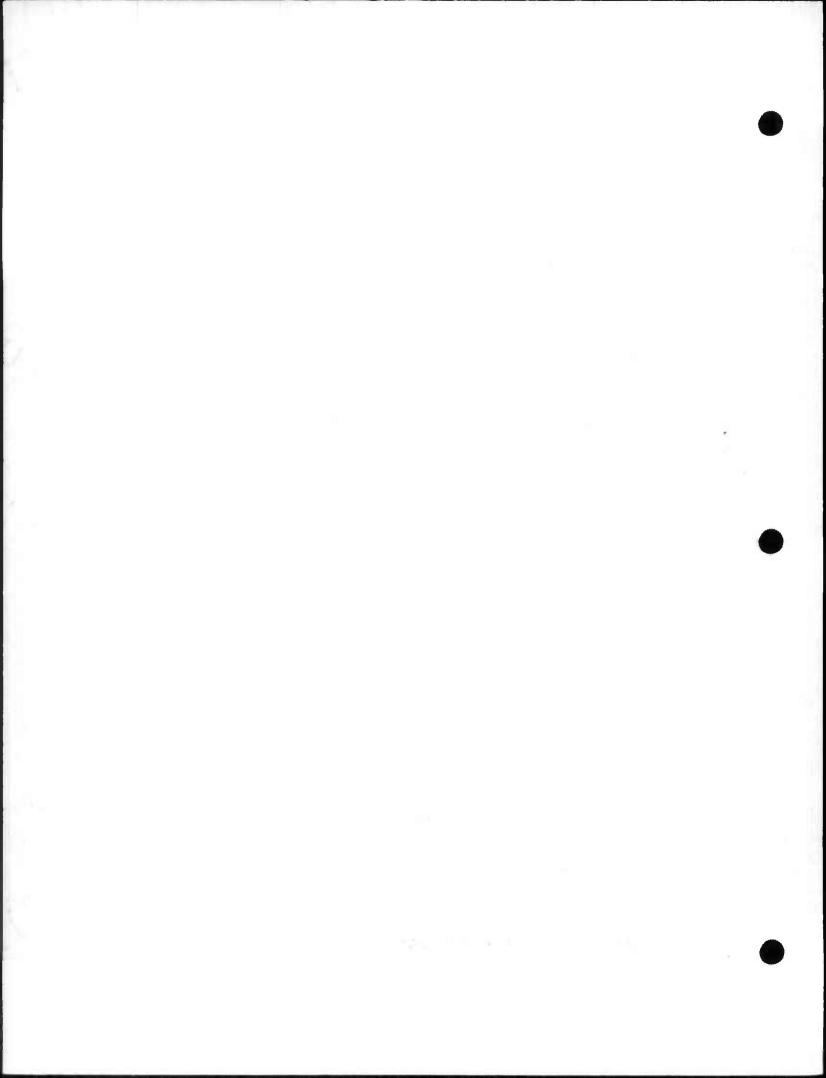


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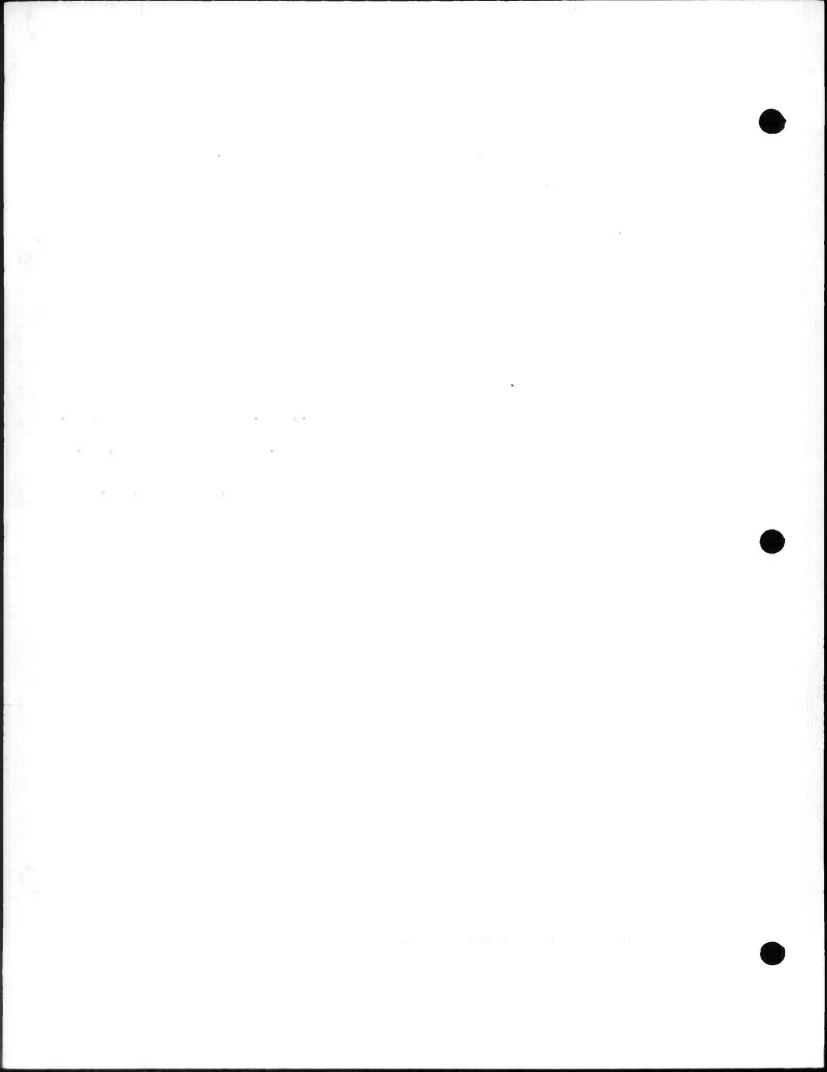
TENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1,		d at once.
ter death. Page 6 may be retail	the funeral director, page 5 shy	moval.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
be executed within a hours at	ian and completely filled in by	or to burial, cremation, or reme	aumatic event, the medic
ires that the death certificate t	signed by the attending physic	Health and Mental Hygiene pric	ws any injury, or other tra
ING PHYSICIAN: The law requ	ifter this certificate has been	eath with the State Dept. of h	marked, or Item 23 show
TO THE HOSPITAL OR ATTENDI	TO THE FUNERAL DIRECTOR: A	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, crematic	IMPORTANT: If item 28 is

	1 - FOR STATE OF N	MARYLAND / DEPA		HEALTH AND	MENTAL HYGIEN	=			
-	1. DECEDENT'S NAME (First, Middle, Last)			DEATH	2. DATE OF DEATH		3. TIME OF DEATN		
	Roger Hoffman, Sr.				монтн ом 06 1		R		
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. last birthda	y) IF UNDER 1 YE	AR IF UNDER 24 HRS.	7. DATE OF BIRTH		RTNPLACE (State or Foreign		
	216-14-9853 1 M 2 G F					07-04-13 Maryla			
DIRECTOR	Peninsula Regional Medical Center Salisbury Wicomico								
300	TA COLUMN						10d. INSIDE CITY		
	Maryland Somerset	merset Wenona				LIMITS?			
FUNERAL	10e. STREET AND NUMBER	STREET AND NUMBER 10f. ZIP CODE				OF WHAT COUNTRY?			
E	23213 Paul Benton Circle	ron Circle 2187							
5	EGDGEGG 4	T EVER IN U.S. ARMED			NIC ORIGIN? (Specify Yes	or No.— 14. R	ACE — American Indian,		
BY F	IF YES, GIVE V	X YES 2 □NO MAR OR DATES		, specify Cuban, Maxico YES 2 X NO Special		Heck, White, etc.			
	1 44 44 11						white		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Give kind	T'S USUAL OCCUP of work done during		16b. KIND OF BUS	SINESS/INDUSTR	Y		
E	Elementary/Secondary (0-12) College (1-4 or 5)	T use retired.)		CI . I .				
MP	7th grade	builde	er		Shipbui				
	17. FATHER'S NAME (First, Middle, Last)				AME (First, Middle, Maiden	Surname)	1.0		
BE	Stanley Hoffman			Helen [
2	19a. INFORMANT'S NAME (Type/Print)				Route Number, City or Tow				
	Beverly Walters				eal Island, N				
- N	20a. METNOO OF DISPOSITION 1XI Burlel 2 Cremation 3 Ramoval from State	20b. PLACE AND DA			DATE 20c. LO	CATION — City o	r Town, State		
	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	- 15t. Paul	JM Chui	ch Cemete	ery6/15 Wer	iona, Mo	aryland		
	The second second)	22. NAM	E ANO ADDRESS OF H	иситу 1213 Је	rsey Ro	ad		
	Patricia (1.)	Alley	Jolle	y Memorio	al Chapel -	Salisbur	y, MD 21801		
	23. PART i. Enter the diseases, or complications the shock, or heart failure. List only one cau	t caused the death. D	o not antar tha	moda of dying, suc	ch as cardiac or respi	retory arrest,	Approximate		
	IMMEDIATE CAUSE (Final	ise on sacrifina.					intarval Between Onset and Daath		
	disease or condition	vocardial	Infarcti	on			7½ hours		
	DUE TO	yocardial (OR AS A CONSEQUENCE	OF):				7-2 HOULS		
z	Arterio	Arteriosclerotic Cardiovascular Disease years							
OE.	it arry, lauding to immediata	(OR AS A CONSEQUENCE	OF):						
S	cause, Entar UNDERLYING CAUSE (Disease or injury								
TF	that initiated events OUE TO resulting in death) LAST	(OR AS A CONSEQUENCE	OF):						
CERTIFICATION	d								
AL C	PART II. Other aignificant conditions contributing to	daath but not rasultin	ig in the under	ying cause given in	Part i. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS		
S	Fractured Rt Hip				PERFOR	200	AMILABLE PRIOR TO COMPLETION OF CAUSE		
ED	Renal Failure				1 TES 2	X NO	DF DEATH?		
2	DID TOBACCO USE CONTRIBUTE	TO CAUSE C	DE DEATH	YES IT NO			1 YES 2 NO		
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL	- TO CAUDE C		L PLACE OF DEATH (C)					
SIC	EXAMINER? 1 X YES 2 NO 1 X Inpatient 2	ER/Outpetlant 3 DOA	OTHER:						
HX	27. MANNER OF DEATN 28a. DATE OF	INJURY 26b.		Home 5 Realdence	28d. DESCRIBE NOW I	NURY OCCURE			
	1 Netural 5 Pending (Month, D	ay, Year)	INJURY	WORK? YES 2 X NO					
ВУ	3 Suickle 28s. PLACE O	F INJURY — At home, farr			Chair leg				
	Mambalda determined building,	etc. (Specify) 9111 Deal			City or Town, State)				
COMPLETED	AND CENTIFIED				Wenona, M				
MP	(Check only one) 2 MEDICAL EXAMINER: On the best of MEDICAL EXAMINER: On the basis of a						mreses		
00		ANTIGOT AND OF REPORTS	stron, in my opinic	n, death occured at the	time, data and place, an	d due to the cau	se(a) and manner as stated.		
B	396. SUGHATURE AND TITLE OF CERTIFIER	am.		29c. LICENSE NU	MBER	29d. DATE SIG	NEO (Month, Day, Year)		
2	38. AANE ANO AOORESS OF PERSON WHO COMPLETED CAU	and a line	D.M.E.	D03599		06-1	3-95		
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	John T. Bulkeley, M.D., 10	o rine Biul	TT KOAd,	Salisbur	y, Maryland	z, 2180.	L		
	JUN 16 1995	Auction Rad I							
	0014 TO 1000 1								



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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 mi	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must
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SARAH ELIZABETH 1	ELIZABETH ARRIS 2. DATE OF DEATH MONTH DAY JUNE U 1995 0745 M 8. AGE (In yrs. last birthday) F UNDER 1 YEAR MONTHS DAYS HOURS MIN. 7. DATE OF DEATH AND 1995 1907 8. SHRTHPLACE (State or Foreign Country) DEAL ISLANG BOLITY, TOWN OR LOCATION OF DEATH EDICAL CENTER SALISBURY 2. DATE OF DEATH MONTH DAY 1995 0745 M 8. SHRTHPLACE (State or Foreign Country) DEAL ISLANG 9c. COUNTY OF DEATH WICOMICO							
A SOCIAL SECURITY NUMBER 219-05-8106 1	8. AGE (In yrs. lest birthdey) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH AND 1997. DEAL ISLANG Country) DEAL ISLANG DEAL CENTER SALISBURY WICOMICO							
PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO TREGIONAE PO FORCEDENTY MD. SOMERSET	EDICAL CENTER SALISBURY WICOMICO							
TO STREET AND NUMBER 1 1974 EDGE HILL TERRACE 1 1974 EDGE HILL TERRACE 1 1974 EDGE HILL TERRACE 1 1974 EDGE HILL TERRACE 1 1974 EDGE HILL TERRACE 1 1974 EDGE HILL TERRACE 1 1975 USAS ACCORDANCE OF MAKEN THE STAND TO STAND TO STAND THE STAN								
Second Specific	Tout House of the							
Security Specify Spe	RRACE 21853 USA							
190. INFORMANT'S NAME (Typer/Print) 190. INFORMANT'S NAME (Typer/P	S? 1 YES 2 NO If yes, specify Cuben, Maxican, Puerto Rican, stc.) Black, White, etc.							
The Information of Part (Specify) 190. Information name (Specify)	(Give kind of work done during most of working life, Do NOT use retired.)							
The first of the control of the cont	16. MOTHER'S NAME (First, Middle, Maiden Surname)							
22. NAME AND ADDRESS OF FACILITY 23. PART I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, ehock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) 24. DUE TO (OR AS A CONSEQUENCE OF): Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSE	30380 MAPLE ST., APT. 210; PRINCESS ANNE, MD.							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, ehock, or heart failurs. List only one cause on each lins. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUE	JOHN WESLET CHONCIT CLM. B-12 DEAL ISLAND, MD.							
enock, or heart fellura. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A C	1213 JERSEY ROAD, SALISBURY, MD. 21801							
PART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 24b. WERE AMAIL COMP 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 28b. DATE OF INJURY 28b. INJURY AT 28b. DATE OF INJURY 28b. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED	enock, or haart failura. List only one cause on each lina.							
PART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 24b. WERE AMAIL COMP 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 28b. DATE OF INJURY 28b. INJURY AT 28b. DATE OF INJURY 28b. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events DUE TO (OR AS A CONSEQUENCE OF):							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MED A 26. PLACE OF DEATH (Check only one) EXAMINER? 1 YES 2 NO UNCERTAIN 26. PLACE OF DEATH (Check only one) EXAMINER? 1 PYES 2 NO UNCERTAIN 26. PLACE OF DEATH (Check only one) EXAMINER? 1 PYES 2 NO UNCERTAIN 26. PLACE OF DEATH (Check only one) EXAMINER? 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNET OF DEATH 28. DATE OF INJURY 28. DATE								
1 YES 2 ND 1 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DESTR. 26e. DATE OF INJURY (Month, Day, Year) 28. DATE OF INJURY 28b. TIME OF 18b. TIME OF 18b. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED INJURY WORK?	DUE TO (OR AS A CONSEQUENCE OF): ting to death but not resulting in the underlying ceuse given in Pert i. 24s. WAS AN AUTOPSY PROPRIED? PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?							
28b. INME OF SUBJECT AT 28c. INJURY	DUE TO (OR AS A CONSEQUENCE OF): Constitution of the underlying cause given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO NO NO NO NO NO NO							
CO 2 Accident Investigation M 1 YES 2 NO	DUE TO (OR AS A CONSEQUENCE OF): 24a, WAS AN AUTOPSY PERFORMED? 24b, WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO OF DEATH? 1 YES 2 NO OTHER: 25. PLACE OF DEATH (Check only one)							
28a. PLACE OF INJURY — At home, farm, streat, factory, office determined 28a. PLACE OF INJURY — At home, farm, streat, factory, office building, etc. (Specify) 28a. PLACE OF INJURY — At home, farm, streat, factory, office City or Town, State)	DUE TO (OR AS A CONSEQUENCE OF): Consequence of the content of							
29a. CERTIFIER (Check only one) 29a. CERTIFVINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner ee stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end in the cause of the	DUE TO (OR AS A CONSEQUENCE OF): Consequence Conseque							
I 29h SIMBATI IDE AND ZITI E DE DEDTIESED	DUE TO (OR AS A CONSEQUENCE OF): Description of the underlying ceuse given in Pert i. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO NO NO NO NO NO NO							
31. DATE FILED (Month, Day, Year) 32. Degistrap's Signature JUN 16 1995 July d'involve Randell	DUE TO (OR AS A CONSEQUENCE OF): Ding to death but not resulting in the underlying ceuse given in Pert i. 24a. WAS AN AUTOPSY FINDINGS ANILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO 1 YES 2 NO NO PEATH? NO PEATH? 1 YES 2 NO NO PEATH? NO P							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the float hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR	STATE OF MARYLAND	/ DEPARTMEN	NT OF	HEAITH AND	MENTAL HYGIEN		20041
	1 - STATE REGISTRAR		ERTIFICAT			REG. NO		
	1. DECEDENT'S NAME (First, Middle, Last) LINWOOD	THOMAS	1	tit	CH JR	2. DATE OF DEATH	AY YEAR 95	3. TIME OF DEATH / 1807 M
	4. SOCIAL SECURITY NUMBER 215-18-4695	5. SEX 8. AGE (In yrs. Is	YRS. IF UND	ER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) July 29, 192	Cour	THPLACE (State or Foreign ntry) TYland
TOR	9a. FACILITY NAME (If not institution, give str PENINSULA REGIONAL RESIDENCE OF DECEDENT		OR LOCATION OF D	EATH	9c. COUNTY OF WICON			
DIRECTOR	10a. STATE 10b. COUNTY	icomico	10c. CITY, TOWN	sbur				10d. INSIDE CITY LIMITS? 1 🖾 YES 2 🗍 NO
FUNERAL	1400 Westcheste	r St.		10	H. ZIP CODE 2 180 1		10g. CITIZEN OF	WHAT COUNTRY?
ВУ	1 Never Married 2 Married FORCES? 1 YES 2 NO				WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— yes, specify Cuban, Maxican, Puerio Rican, etc.) YES 21 NO Specify: White			
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	ECEDENT'S USUAL Give kind of work don b. Do NOT use retired hanical	e during m	ost of working		siness/industry	ice
TO BE COM	17. FATHER'S NAME (First, Middle, Last) Linwood Thomas H		Hanteat	Birgi		ME (First, Middle, Maiden		s
	19a. INFORMANT'S NAME (Type/Print) Gary L. Hitch	11	5521 St.	ss (Street And	end Number or Rural rews Dr.	Aoute Number, City or Tow , Salisbur	y, MD 21	801
	20e. METHOD OF DISPOSITION 1							
	22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801							MD 21801
	Approximate shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition							
CERTIFICATION	resulting in death) Due to (or as a consequence of): Cofon Afra Afra Disease Due to (or as a consequence of): Due to (or as a consequence of): Cofon Afra Afra Disease Due to (or as a consequence of): Severe Left Ventricular Dysfunction Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LENAL FAILURE, SEVERE PERIPHERAL VASCULAR DVS FASE, SIP AXABLEDICIAL SYPASS DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN O							
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOPPITAL: OTHER:							
PHYSICIAN:	1 YES 2 NO 27. MANNER OF DEATH	1 ☐ Inpatient 2 ☐ ER/Outpatient ;		raing Hon	ome 5 Residenca 6 Other (Specify)			
BY P	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	1 🗆	NJURY AT 28d. DESCRIBE HOW INJURY OCCURED WORK? YES 2 NO			
ETED	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY — At he building, atc. (Specify)				261. LOCATION (Street a City or Town, State)		Route Number,
COMPLETED		IAN: To the beef of my knowledge, do: On the beels of examination and/or						(a) and menner as stated.
TO BE	296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Morith, Day, Year) 30. NAME AND ADDRESS OF RESSON TO COUNTY SEE							D (Month, Day, Year)

COMPLETED CAUSE OF DEATH (ITEM 27) (Type,

MEGISTRAR'S SIGNATURE

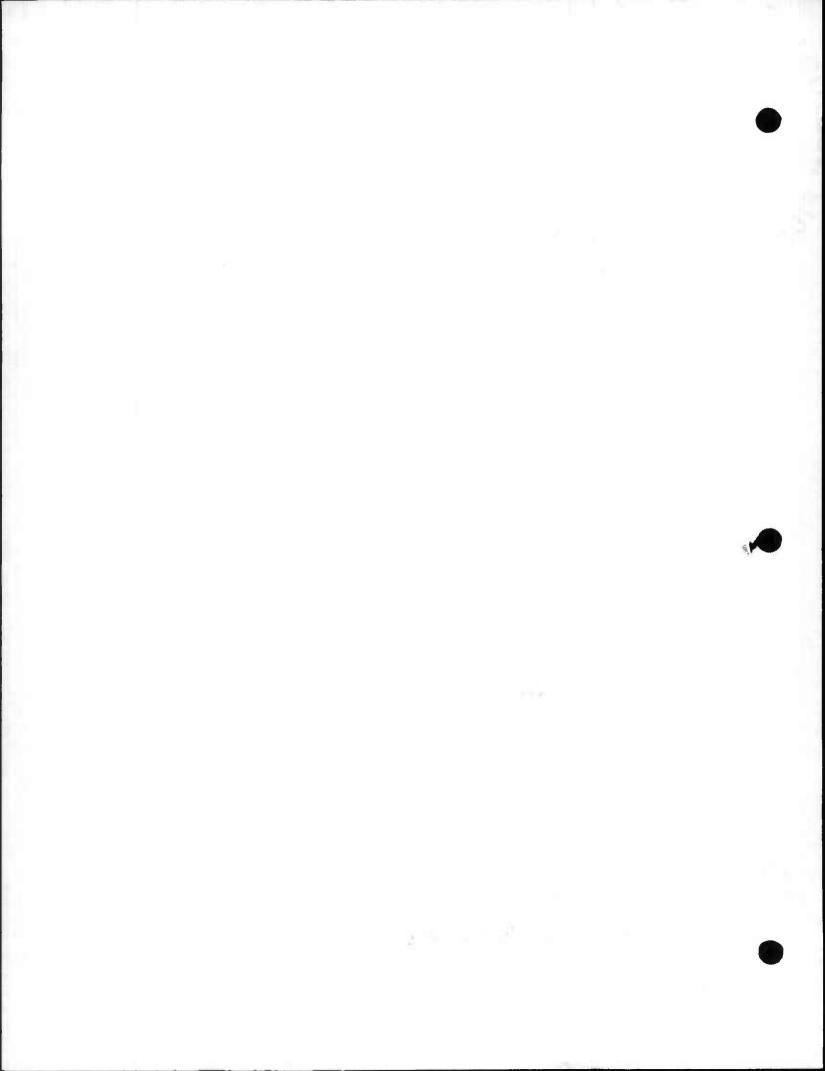
PERSON

Day 2

Year)

31. DATE FILED (MOORT)

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Pages 1, 2, 3 should

permit, hours after death. Page 6 may be retained by the hospital or attending physician.

ed in by the funeral director, page 5 should be detached for use as the buriat-transit to refine the state of the sta 76 notified 9 examiner medical attending physician and completely filled in by intal Hygiene prior to burial, cremation, or remo the th traumatic event, executed with requires that the death certificate be other t 0 n signed by the attend f Health and Mental H any Shows been . DR ATTENDING PHYSICIAN; The law I DIRECTOR: After this certificate has be hours after death with the State Dept. 23 tem 0 marked, 28 Hem HOSPITAL FUNERAL within 72 h

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

once.

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MEDICAL

PHYSICIAN:

BY

COMPLETED

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IMPORTANT: If

표 P.P.8

hlh 95 20642 6/23/95 ELM P.G.C. FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Darnose LaJuan Harris June 20 995 0200 A SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign DAYS HOURS MIN. 577-88-9116 1 M 2 X F 29 YRS JUN 24,1965 WASH., D.C. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 6800 blk. Riverdale Road Riverdale Prince Georges 10h COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY NA NA WASHINGTON, D.C. 1 K YES 2 NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2005 MARYLAND AVENUE N.E. #7 20002 UNITED STATES 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ∑ NO IF YES, GIVE WAR OR DATES 11 MADITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1X Never Married 2 Married BY 3 Widowed 4 Divorced BLACK ETED 15. DECEDENT'S EDUCATION 18s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) COMPL PAPER INSERTER 11 NEWSPAPER PUBLISHING 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) LARRY DAVID HARRIS, SR. DIANA LYNN THOMAS BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 DIANA LYNN CAMPBELL 960 DIVISION AVENUE, N.E. WASHINGTON, ND.C. 20019 20s. METHOD OF DISPOSITION
12 Deurlai 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - Cify or Town, Steta 4 Donation 5 Other (Specify) LINCOLN CEMETERY 16/27 BRENTWOOD. MARYLAND 21. BIGHATURE OF FUNDRAL SERVICE LICENSEE, 22. NAME AND ADDRESS OF FACILITY ALEXANDER S. POPE FUNERAL HOMES M859 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or reepiratory errest, shock, or heart failure. List only one cause on each line. Approximate **IMMEDIATE CAUSE (Fine) Onset and Death** disease or condition Shot Lead wound brun reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events

resulting in deeth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24e. WAS AN AUTOPSY PERFORMED? 246. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 | NO 1 YES 2 NO

Tune

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO INCERTAIN I 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA R:
rsing Home 5 - Residence 8 Yother (Specify) at scene 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation -20-95 155 AM 1 YES 2 NO subject Shot 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 47 Homicide Stract vardale Rd P.G.10

(Check only	1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, deta and place, and due to the cause(a) and manner as stated.
one)	2X MEDICAL EXAMINER: On the basis of exemination and/or investigation in my opinion death occurred at the time date and place and due to the care

the cause(e) and manner as stated. 286. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

O.C

M.E

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

avid FOULER 111 Penn Street, Baltimore, Maryland 21201 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

Julia Davidson Randall 23 1995

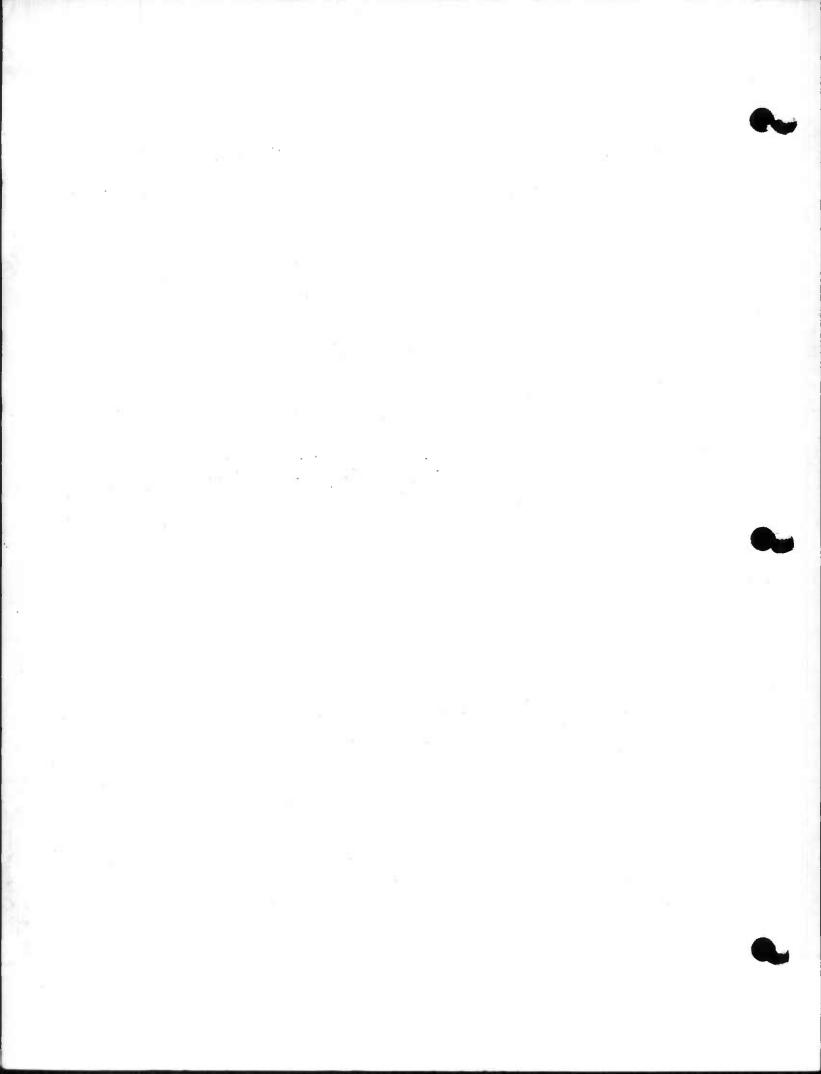
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DIVISION OF VITAL RECORDS P.O. ROX 6876

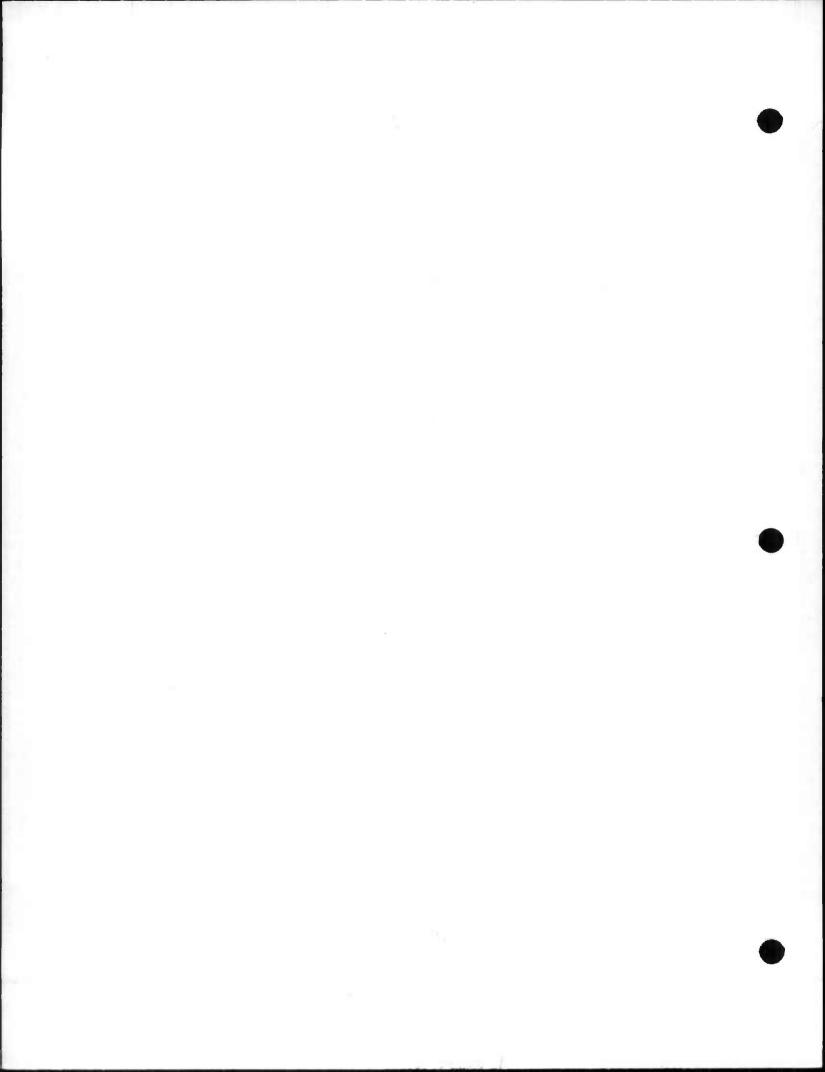
BALLIMORE, MARITAND 21213-0020	VESCIAM: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hospital or attending physician.	a confidence has been sooned by the attraction provided and companies and companies of contraction, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	the medical examiner must be notified at once.
The work of the property of th	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and compilities filled in by the filled under 25 hours after duals have been their an attending to the filled to by the filled under the filled to by the filled to by the filled to by the filled to by the filled to by the filled to by the filled to by the filled to by the filled to by the filled to by the filled to by the filled to by the filled to by the filled to by the filled to by the filled to be filled to by the filled to by the filled to be filled to by the filled to be filled to by the filled to be	IMPORTANT If them 28 is marked, or them 23 shows any lajury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL			OF HEALTH AI		NTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)						DATE OF DEATH	AY YEAR	3. TIME OF OEATH
		Clark L. Haynes 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birth					June 19, 1995 3:		3:30 A. M
	577-22-0017		36 YRS.	MONTHS (WIN.	(Month, Day, Year) ept. 20,	Cou	THPLACE (State or Foreign ntry) LXQS
	Sa. FACILITY NAME (If not institution, give			9b. CITY, T	OWN OR LOCATION			9c. COUNTY OF	
DIRECTOR	Sylvan Manor Nu	rsing Home		Sil	ver Spri	ng		Montgom	ery County
IRE				Y, TOWN OR LOCATION			10d, INSIDE CITY LIMITS?		
	Maryland Prine	Ac	delphi				1 TYES 2 NO		
BA	10808 Ashfield Re			101. ZIP CODE	02			WHAT COUNTRY?	
	11. MARITAL STATUS	12. WAS DECEMENT EVER II	N U.S. ARMED	20783 United Sta					CE - American Indian
BY FUNERAL	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? t YES			res, specify Cuben, N	Mexican, Pr Specify:	uarto Rican, atc.)		ck, white, etc. oc/ly: White
COMPLETED	15. OECEDENT'S EDU (Specify only highest grade	JCATION e completed)	18a. DECEDENT'S	USUAL OCC	UPATION ring most of working		16b. KIND OF BU	SINESS/INOUSTRY	MITTO
LE	Elementery/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	se retired.)					
Š	17. FATHER'S NAME (First, Middle, Last)		Self-Em	ртоуе		O'S NAME /	Vending First, Middle, Malden	<u>Machin</u>	es
	Ira Haynes				200000000000000000000000000000000000000		t Heith	Surrieme),	
O BE	19e. INFORMANT'S NAME (Type/Print)				Street and Number or	Aural Route	Number, City or Tow		
Ĭ	Nellie R. Haynes	l an			ield Roa	d, A			
	1 X Burial 2 Cremation 3 Ran 4 Donation 5 Other (Specify)	noval from State can	o. PLACE ANODATE netery, crematory or o Ort. linc	thar placal		6/21	- 1	CATION — City or	
	21. SIGNATURE OF FUNERAL SERVICE LI		O'L LINC	1 22 NA	ME AND ADDRESS	OF FACILITY	TV		Maryland
	· Mark	7. Yuk	ley	1 50	rt Linco	In Fu	uneral Ho	ome, Inc	d, MD 20722
CERTIFICATION	ahock, or heert fellure. List only one cause on each line. Interval Between Onset and Death Cause (Finel disease or condition resulting in death) Due to (or as a consequence or): Due to (or as a consequence or): Due to (or as a consequence or): Due to (or as a consequence or): Due to (or as a consequence or): Due to (or as a consequence or): Due to (or as a consequence or): Due to (or as a consequence or):								
MEDICAL C	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PINDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH 1 YES 2 NO 1								
	DID TOBACCO USE	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO							
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:	26. PLACE OF DEAT	TH (Check o	only one)		
PHYS	1 YES 2 NO	1 Inpatient 2 ER/Outs 28a. OATE OF INJURY	patient 3 DOA	Nursin	g Home 5 🗆 Rasid				
2	1 Natural 5 Pending	(Month, Day, Year)	IN.	JURY M	WORK?		d. DESCRIBE HOW	NJURY OCCURED	
TED B	2 Accident Investigation 3 Suicide 8 Could not be determined determined determined 28e. PLACE OF INJURY — Al home, farm, street, lactory, office building, etc. (Specify) 28l. LOCATION (Street and Number or Rural Route Number, City or Yown, State)						I Route Number,		
	29a. CERTIFIER A TO PROTECTION TO THE PROTECTION TO THE PROTECTION OF THE PROTECTION								
COMPLE		ER: On the basis of examinstic							(s) and manner as stated.
H	29b. SIGNATURE AND TITLE OF CENTIFE Whole		Man		29c. LICENS				(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WI	10 COMPLETEO CAUSE OF DE	ATH (ITEM 27) (Type	Print) 2	309 1	BAI	5 H510	RO	171
	MYRON L.	LENKIN		ű	HEAN	200	MD	/-	
	JUN 21 1995	12. REGISTRAR'S SIGN	Lall						
	1 0011 × 1 1999 0.		1211						



BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician,	OIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should hours after death with the State Dept. of Health and Mental Alygiene prior to burial, cremation, or removal.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPART CERTIFIC	MENT OF HEALTH AND	D MENTAL HYGIENE REG. NO.	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. last birthday)	IMPHRIES,	(Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
TOR	9a_EACILITY NAME (If not institution, give street	X M 2 L F 51 YRS.	No. CITY, TOWN-OF LOCATION OF	March 5, 1944	Washington, D
AL DIRECTOR	Maryland Prin		Temple Hills	100	10d. INSIDE CITY LIMITS? 1 🔀 YES 2 🗌 NO 1. CITIZEN OF WHAT COUNTRY?
BY FUNERAL	3128 Brinkley Road 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Proproceed	d, Apt. 201 2. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYS 2 TYNO IF YES, GIVE WAR OR DATES	2074 13. WAS DECENDENT OF HIS If yes, specify Cuban, Mex 1 YES 2X NO Spe	PANIC ORIGIN? (Specify Yes or Nicon, Puerto Rican, etc.)	United States - 14. RACE — American Indian, Black, White, etc.
COMPLETED E	15. DECEDENT'S EDUCA (Specify only highest grade co	mpleted) (Give kind of wo life. Do NOT use	k done during most of working retired.)	16b. KIND OF BUSINES	
i I	12th 17. FATHER'S NAME (First, Middle, Last) Jefferson Will	Ma:	intenance 16. MOTHER'S	NAME (First, Middle, Meiden Sume Helen Kin	,
TO BE	190. INFORMANT'S NAME (Type/Print) Helen Humph: 200. METHOD OF DISPOSITION	19b. MAILING A	Brinkley Road, Apt	ral Route Number, City or Town, Ste t. 201; Temple Hi	ne, Zip Code) 11s, Md 20748
CAGINITION INCOME.	1 G Burfel 2 Cremation 3 Removi	cemetery, crematory or othe	norial Park 22. NAME AND ADDRESS OF 4001 Bennin	6/21/95 L FACILITY Stewart Ig Rd., N.E. W	andover, Md Funeral Home ash., D.C. 20019
event, the medical	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	bue To (or as a consequence or):	rates D	Trees Sy	y arreat, Approximate interval Betw Onset and D
CERTIFICATION	Sequentisity list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):	of a w	/	gear
MEDICAL	Renal Far	contributing to deeth but not resulting in	the underlying ceuse given	in Part I. 24a, WAS AN AUTO PERFORMED? 1 YES 2 PR	AVAILABLE PRIOR TO
PHYSICIAN:		26. PLACE OF OEATH	THER:		
<u>a</u>	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year) 28b. TIME (INJUR	WORK? M 1 YES 2 NO	28d. DESCRIBE HOW INJURY	Y OCCURED
NOM 28 IS	3 Suicide 4 Homicide 6 Could not be determined 29e. CERTIFIER (Check only) 1 CERTIFYING PHYSICIA	26s. PLACE OF INJURY — At home, term, stre building, etc. (Specify) N: To the best of my knowledge, death occurred		28t. LOCATION (Street and Nu. City or Town, State)	
IMPORTANT: It item 2 TO BE COMPLET	29b. SIGNATURE AND TITLE OF CERTIFIER	On the beels of examination end/or investigation,	In my opinion, death occured at t	the time, data and place, and dua	DATE SIGNED (Month, Day, Year)

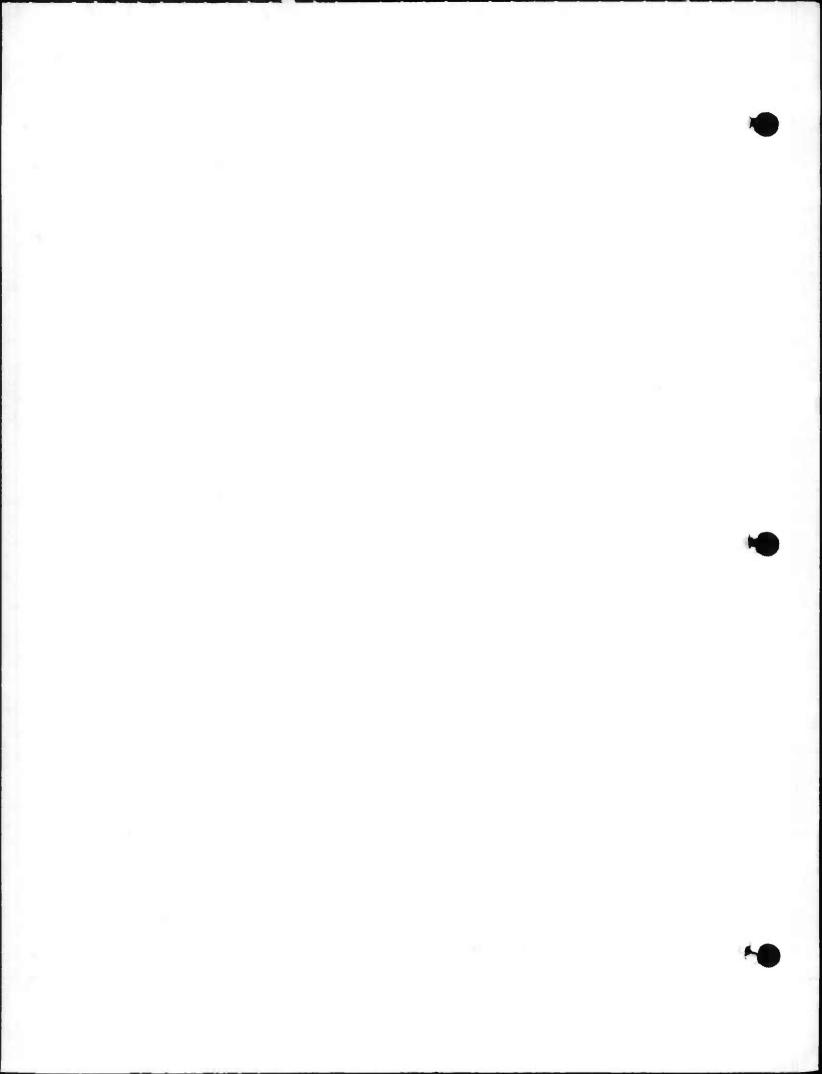


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after death. Page 6 may be retained by	를	
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

ours after death. Page 6 may be retained by the hospital or attending physician.	I in by the funeral director, page 5 should be detached for use as the burial-tran or removal.	nedical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with Ahours after death. Page 6 may be retained by the hospital or attending physician	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trial be filled within 72 hours after death with the State Debt, of Health and Mental Hydene prior to burial, cremation, or ramoval.	IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND A	DEPARTMENT ERTIFICATE	OF HEALTH AND		E	
	1. DECEDENT'S NAME (First, Middle, Lest)	EIIIII IOATE	OI DEAIII	REG. NO.		3. TIME OF DEATH
	NATHANIAL MOSES WILLIAM HALL			June 15	1995	8:40 p M
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. la:		YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRTI	HPLACE (State or Foreign
	577-66-0824 1 M 2 F 47 9e. FACILITY NAME (If not institution, give street end number)	YRS.	DAYS HOURS MIH.	Oct. 14,	1947Colu	mbia, S.C.
DIRECTOR	Doctors Hospital	Lanha			ec. COUNTY OF D	
EC	10e. STATE 10b. COUNTY	10c. CITY, TOWN OR	LOCATION			10d. INSIDE CITY
E	N/A N/A	Washingt	on D C			LIMITS?
	100. STREET AND NUMBER	washingt	10f. ZIP CODE		10g. CITIZEN OF	1 X YES 2 NO
ER/	1427 Monroe Street		20017		U.S.	
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AF		S DECENDENT OF HISPAI	NIC ORIGIN? (Specify Yes		E — American Indian, k, White, etc.
BY	1 Never Merried 2 Merried FORCES? 1 YES 2 XI 3 Wildowed 4 Divorced FYES, GIVE WAR OR DATES		res, specify Cuben, Mexice YES 2 KNO Specif		Blac Spec	
COMPLETED	15. OECEDENT'S EDUCATION (Specify only highest grade completed) (G	ECEDENT'S USUAL OCC	UPATION	16b. KIND OF BUS	INESS/INOUSTRY	DIACK
ᆸ		alve kind of work done dur b. Do NOT use retired.)	ring most of working			1
M M	12th L	aborer		pri	vate	
흥	17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NA	ME (First, Middle, Maiden :		
8	Nathaniel Moses Richard Hall		Wilhelmi	na J. Burg	gess	
2		b. MAILING AOORESS (S	Street and Number or Rural i	Route Number, City or Town	, State, Zip Code)	
-		2026 Halla	ndale Terr	. Mitchilly	ville,MD	20721
	TX Burlai 2 Cremation 1 Removal from State Lemetery, cre	AND DATE OF DISPOSITI		OATE 20c. LOC	CATION — City or To	own, State
	21. BIOHATURE OF FUNERAL SERVICE LICENSEE	<u>ny Memoria</u>		June 20 La	andover,	MD.
	IT STORY OF POPENIC DESTRICE LICENSES	J.B.	ME AND AODRESS OF FA Jenkins F	uneral Home	9	
	- B	- 2 747	4 Landover	, RD. Lando	over, MD	20785
	23. PART I. Enter the diseases, or complications that caused the de shock, or heart failure. List only one cause on each line	eath. Do not enter th	e mode of dying, suc	h es cardisc or respir	atory srrest,	Approximate
	IMMEDIATE CAUSE (Final	•				interval Between Onset and Death
	disease or condition resulting in death)	Intra Cere	bral Hemmo	rhage		36 hrs
	DUE TO (OR AS A CONSE	OUENCE OF):				
8	Sequentially list conditions, D. OUE TO (OR AS A CONSE	ncontrolle	d Blood Pro	essure		
CERTIFICATION	if any, leading to immediate course. Enter UNDERLYING	OUENCE OF):				
윤	CAUSE (Disesse or injury that initiated events DUE TO (OR AS A CONSE	OUENCE OF):				
E	resulting in desth) LAST					
	DAOT II OAL - L-III - ALL III - ALL					
8	PART II. Other significant conditions contributing to deeth but not r	resulting in the unde	riying ceuse given in	Part I. 24a. WAS AN / PERFORI		WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
ă				1 TES 2	NO D	COMPLETION OF CAUSE OF DEATH?
Σ	DID TORACCO LICE CONTRIBUTE TO CALLCE OF DEA					1 TYES 2 NO
A N	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEA	E OF DEATH (Check only		<u> </u>		
딣	EXAMINER? HOSPITAL:	OTHER:				
PHYSICIAN: MEDIC	1 ☐ YES 2 【XNO		g Home 5 Residence	8 Other (Specify) 28d. DESCRIBE HOW IN	HIRV OCCUPED	
	Natural 5 Pending (Month, Day, Year)	INJURY	WORK?	280. DESCRIBE HOW IN	JUHY OCCURED	
B	2 Accident Investigation 3 Suicide 8 Could not be 28e. PLACE OF INJURY At ho			281. LOCATION (Street or	od Number or Burel 6	Bruto Mumber
COMPLETED	Success 8 Could not be determined Homicide determined building, etc. (Specify)			City or Town, Stete)	o number of nurer r	NOOTO NAMEDEN,
	29e. CERTIFIER (Check only 1 XCERTIFYING PHYSICIAN: To the best of my knowledge, de	oth commend of the Man				
E I	(Check only one) 2 MEDICAL EXAMINER: On the best of exemination end/or in					
	296. SIGNATURE AND TITLE OF SENTIFIER					
#	Va L		29c. LICENSE NUM	BER	29d. DATE SIGNEO	
2 ∦	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITER	M 27) (Type Print)	D 43446		6/16/	795
	ROINTAN FARAHI- FAR 4000 Mitche		Road B 216	Bowie, Mo	. 20716	
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE					
	JUN 20 1995 Jahr Stocker Rordell					3.0



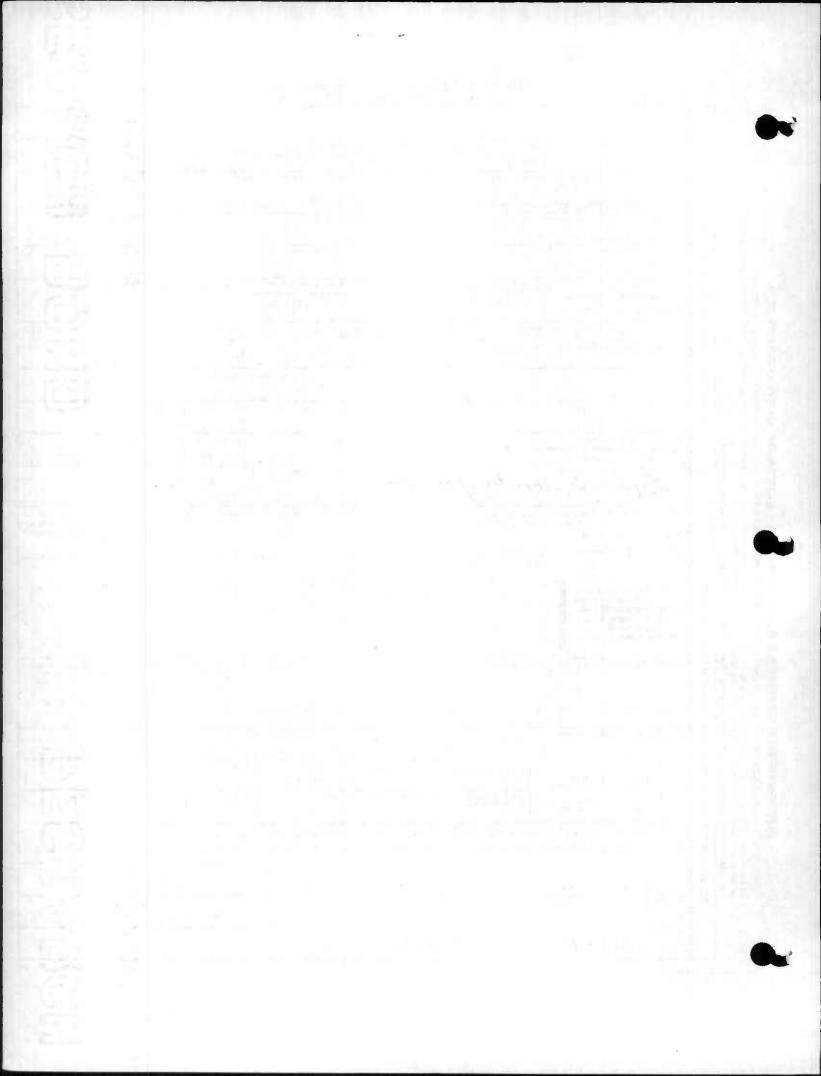
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and local death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netfilled at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

		FOR
1	-	STATE
		REGISTRAR

	1 - STATE REGISTRAR	SIAIE UF N	WARTLAND	ERTIF					MENIA	REG. NO	-			
1 3	1. DECEDENT'S NAME (First, Middle, Last)									OF DEATH			3. TIME OF DEATH	
	GEORGE ROBERT HA	RRIS, SR.							JUN		5. 1	995	1:22	рм
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. Is	ast birthday)	IF UNDER		IF UNDER		7. DATE	OF BIRTH		8. BIRTH	PLACE (State or Foreign	-
	215-26-0423	1 M 2 F	82	YRS.	MONTHS	DAYS	HOURS	MIN.		H 10,	1913	Countr	GINIA	
	Sa. FACILITY NAME (If not institution, give	street and number)			9b. CITY	, TOWN O	R LOCATI	ON OF D		11 10,	9c. COUN			
8	#3338 RIPPLE ROAL	D			BAT.	TIMO	RE				BAL	TIMO	RE	
اقا	RESIDENCE OF DECEDENT 10e, STATE 10b, COUNT	DV.		T 40 . 00										
뿔				1	ry, town o		ION						10d. INSIDE CITY LIMITS?	
	MARYLAND CHAI	RLES			<u>IARBU</u>		ZIP COD	-			I a amu		1 TES 2 NO	
HA	The same of the sa	O.P.				101.							VHAT COUNTRY?	
	#4357 HARRIS PLAG	12. WAS DECEDEN	T EVER IN II S A	PMED	12.5	Wile DECI	206		NIC OBIOIN	l? (Specify Vi			STATES - American Indian.	
BY FUNERAL DIRECTOR	1 Never Married 2 🔀 Married 3 Never Married 2 Divorced	FORCES? 1	YES 2 WAR OR DATES	NO	- 1		city Cube	n, Mexica	en, Puerto I	Rican, etc.)	N 01 NO_	Biaci	t, Whits, etc.	
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad	JCATION		ECEDENT'S					16b	KIND OF BU	JSINESS/IND	USTRY	DETOR	
13	Elementary/Secondary (0-12)	College (1-4 or 6	104	'Give kind of le. Do NOT u	work done (auring mos	ST OF WORKI	ng	EX	TRUSI	ON PL	ANT		
MP		2 YEARS	RE	TIREL	LEA	D MA	N		GO	VERNM	ENT (N.O.	s.)	
8	17. FATHER'S NAME (First, Middle, Last)						18. MOT	HER'S NA	ME (First, I	Middle, Malde	n Surname)			
BE	ROBERT T. HARRIS								UCKNE					
0	19e. INFORMANT'S NAME (Type/Print)										wn, State, Zip			
	BARBARA ALFORD							BAI			ARYLA			
	20a. METHOD OF DISPOSITION	noval from State	20b. PLACE cemetery, cr	rematory or	OF DISPOS	SITION (Ne	me of	071	DAT	20c. L	DCATION -	City or To	ARYLAND	
d	4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE /	- PLEAS.	ANT C		CHU NAME AN				/95 M	ARBUR	Y, M	ARYLAND	
	LYDIA C. THORN	2hantor	SON MOO	583	TH	ORNT	ON F	UNE	RAL H	OME,		HΕΔ	D, MD.2064	40
	23. PART I. Enter the diseases, or	complications the	it caused the d	leath. Do									Approximata	
	shock, or heart failure. IMMEDIATE CAUSE (Final	List Dnly one ceu	use on each lin	ın.									Interval Between Onset and De	
	disease or condition resulting in death)	EESPIR	ATORY F.	AILUR	RE								3 mos.	
			(OR AS A CONS										J mos.	
N	Sequentially list conditions,		ATIC CA			M LU	NGS							
Ĕ	if any, leading to immediate cause. Enter UNDERLYING	DUE TO	(OR AS A CONSI	EOUENCE C	OF):									
CERTIFICATION	CAUSE (Disease or Injury	c	(OR AS A CONSI	EQUENCE O)F):			_						_
Ē	that initiated events resulting in death) LAST				.,,									
		d												
ICAL	PART II. Other algnificant condition	na contributing to	death but not	reaulting	In the un	nderlying	ceuse	given in	Part I.	24a. WAS A	N AUTOPSY	24b	WERE AUTOPSY FINDIN	IGS
음										1 TYES	2 📉 NO	10	COMPLETION OF CAUSE OF DEATH?	E
MED													1 YES 2 NO	
PHYSICIAN:														
호	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER		ACE OF D	EATH (Ch	neck only or	ne)				-
1×S	1 TYES 2 M NO	1 Inpatient 2						aldence	6 Othe					
	1 X Natural 5 Pending	28s. DATE OF (Month, D		26b. TIR	JURY M	28c. INJU	RK?	7 40	28d. OES	CRIBE HOW	INJURY OCC	URED		
ВУ	2 Accident Investigation	26e PLACE C	OF INJURY At h	nome ferm	etraat fact			_ NO	201 1.00	ATION (Steel	and Number	or Rumi 6	Doubs Alumbac	
E	3 Suicide 6 Could not be 4 Homicide determined	building,	atc. (Specify)	tome, rann,	ationt, mot	ory, ornice				or Town, Stati		OF PILITED P	tode Nomber,	
ᄪ	29a. CERTIFIER												13733	
COMPLETED	(Check only one) 1 X CERTIFYING PHYS												i) and manner as stated	d.
	29b. SIGNATURE AND TITLE OF CERTIFIE													
BE	Ce Gil S A	In Por	. 14.	a.			D :	ENSE NU	-7 7		29d. DATI	SIUNED	(Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CALL	SE OF DEATH (IT	EM 27) /3m	e. Prine)		-)	+1	13		1,0	00	610	
	CESIE DE LA PAZ					НЕТ	СИТС	MA	DVIA	ND 2	0745			
	31. DATE FILED (Month, Day, Year)				WE91	HE: I	GIII 2	, PLF	KILA	עואו ע	0743	-		
	JUN 2 8 1995	deli d	R'S SIGNATURE	24-11										



or attending physician. or use as the bunial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

ENDING PHYSICIAN: The law requires that it. After this certificate has been signed by lier death with the State Dept. of Health and I is marked, or Item 23 shows any I is	The state of the s	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or	
ENDING PHYSICIAN: The lands. After this certificate has let death with the State Deg Is marked, or Item 23		shows any Inju	it. of Health and Me	been signed by the	w requires that the	
ENDING PR: After ter deatl		arked, or Item 23	with the State Deg	this certificate has	PHYSICIAN: The lan	
TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTO be filed within 72 hours aff IMPORTANT: If Item 28		TANT: If Item 28 Is ma	d within 72 hours after death	HE FUNERAL DIRECTOR; After	HE HOSPITAL OR ATTENDING	

STATE OF MARYLA	ND / DEPARTMENT OF HEALTH AND	MENTAL HYGIENE
	CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND	DEPARTMENT	OF HEALTH AND	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH
	Madlin M	. Handy				1995 YEAR	12:30 p. M
	0 7 201 2011	5. SEX 8. AGE (In yrs. In	MONTHS	1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. Bif	RTHPLACE (State or Foreign untry)
	9a. FACILITY NAME (If not institution, give stre	1 M 2 DF 93	YRS.	TOWN OR LOCATION OF D	107-15-19	02	MD_
N.	Edw.W.McCready Men	morial Hospital	. (Crisfield	EATH	Somer	
5	RESIDENCE OF DECEDENT					J	
DIRECTOR	10e. STATE 10b. COUNTY	DOMERSET	Wes	RLOCATION VER			10d. INSIDE CITY LIMITS? 1 YES 2 NO
	10a. STREET AND NUMBER	7 10 2	,,,,,,	10f. ZIP CODE	- 1	10g. CITIZEN O	F WHAT COUNTRY?
FUNERAL	11, MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. AF	6	118	//	U.	.).
	1 Never Married 2 Married	FORCES? 1 YES 2	NO I	MAS DECENDENT OF HISPA 1 yea, specify Cuban, Mexic TYS 2 XNO Specify	en, Puerto Rican, etc.)	Bi	ACE — American Indian, ack, White, atc.
D BY	3 Widowed 4 Divorced				y. 		Black
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co	ompleted) (0	ECEDENT'S USUAL OC Give kind of work done on Do_NOT use retired.)	CCUPATION during most of working	16b. KIND OF BU	SINESS/INDUSTRY	,
MPL	Elementary/Secondary (0-12)	College (1-4 or 5+)	LAbore	FR	Do	shestic	
8	17. FACHER'S NAME (First, Middle, Last)			18. MOTHER'S NA	AME (First Middle Meider	Sumame)	
8	KHYTICID HAND	/		-		DING	
2	190. INFORMANT'S NAME (Type/Print) KEII4 LONG	P	O. Box 26	(Street and Number or Rural	· MA	n, State, Zip Code)	1
	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remove		AND DATE OF DISPOS		A PATE 20c LC	CATION - City or	
	4 Donation 5 Other (Specify).		PMRION OF Other place)		194/95 M	LEST OVER	all.
	The side of the source of the	2/0	- F	NAME AND ADDRESS OF FA	AVD Tuncial	Home	1
_	" fachy (. wan	30	639 Hampden A	WE. Princes	s Anne	UD. 21853
	23. PART 1. Enter the diseases, or con shock, or heart failure. Lis	mplications that caused the de at only one cause on each line	eath. Do not enter	the mode of dying, suc	h ss cerdiac or resp	Iratory srrest,	Approximate Interval Between
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	RENAL	Failu	rl			Onset and Beath
_		OUE TO (OR AS A CONSE	OUENCE OF):	NOT FA	1 LURE		1/2
CERTIFICATION	Sequentially list conditions, if sny, leading to immediate	DUE TO (OR AS A CONSE	OUENCE OF):		/ CONT		
S	cause. Enter UNDERLYING CAUSE (Disease or Injury	D'alelles	Mell	ilus			
Ë	that initiated events resulting in death) LAST	DIS 11 to ON AS A CONSE	OUENCE OF):	10			
CE	d .	1 mai	Mas				
Ä	PART II. Other eignificent conditions of MT3405C	contributing to deeth but not	no of	derlying couse given in	Part I. 24s. WAS AN PERFOI		4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
OG	MICHOSC	1 mile He	wil &	nsease	1 🗀 YES 2	NO	COMPLETION OF CAUSE DF DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIL	RUTE TO CALISE OF DEA	TH VEC TO A	IO UNCERTAI			1 TYES 2 NO
MA	25. WAS CASE REFERRED TO MEDICAL		CE OF DEATH (Check of		101		
SIC		OSPITAL: Inpatient 2 ER/Outpatient 3	OTHER	: ing Home 5 - Rasidence	8 Other (Specify)		
Ŧ	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Dey, Year)	1	28c. INJURY AT WORK?	28d. DESCRIBE HOW	NJURY OCCURED	
BY	1 Natural 5 Pending 2 Accident Investigation		M	1 YES 2 NO			
COMPLETED	3 Suicide 8 Could not be determined	28s. PLACE OF INJURY — At he building, etc. (Specify)	ome, farm, street, facto	ery, office	281. LOCATION (Street City or Town, State)	and Number or Rura	al Route Number,
PE	29a. CERTIFIER 1 CERTIFYING PHYSICIA	AN: To the best of my knowledge, de	eath occurred at the til	me, data and place, and due	to the cause(a) and ma	oper an stated.	
OM		On the besis of examination and/or					e(a) and manner as stated,
w III	290. SIGNATURE AND TITLE OF CERTIFIER	_		29c. LICENSE NUI	MBER	29d. DATE SIGNI	ED (Month, Day, Year)
TO B	1 Hose aran	PANO		0) 2	9987	. 1	e 21,1995
F	Dr. Albert Dacana	P.O. Box 180	M 27) (Type, Print)	City Md 2	1842		1.10
	31. DATE FILED (Month, Day, Year)	Tan BEGISTRADIO GIGUISTICE	, occan	O10, 114. 2	. 1976		
	TILLIA 7 4001	32. REGISTRAR'S SIGNATURE	Rardall				
	JUN 2 / 199	1 /					

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the flow is the death. Page 6 may be retained by the hospital or attending physician.

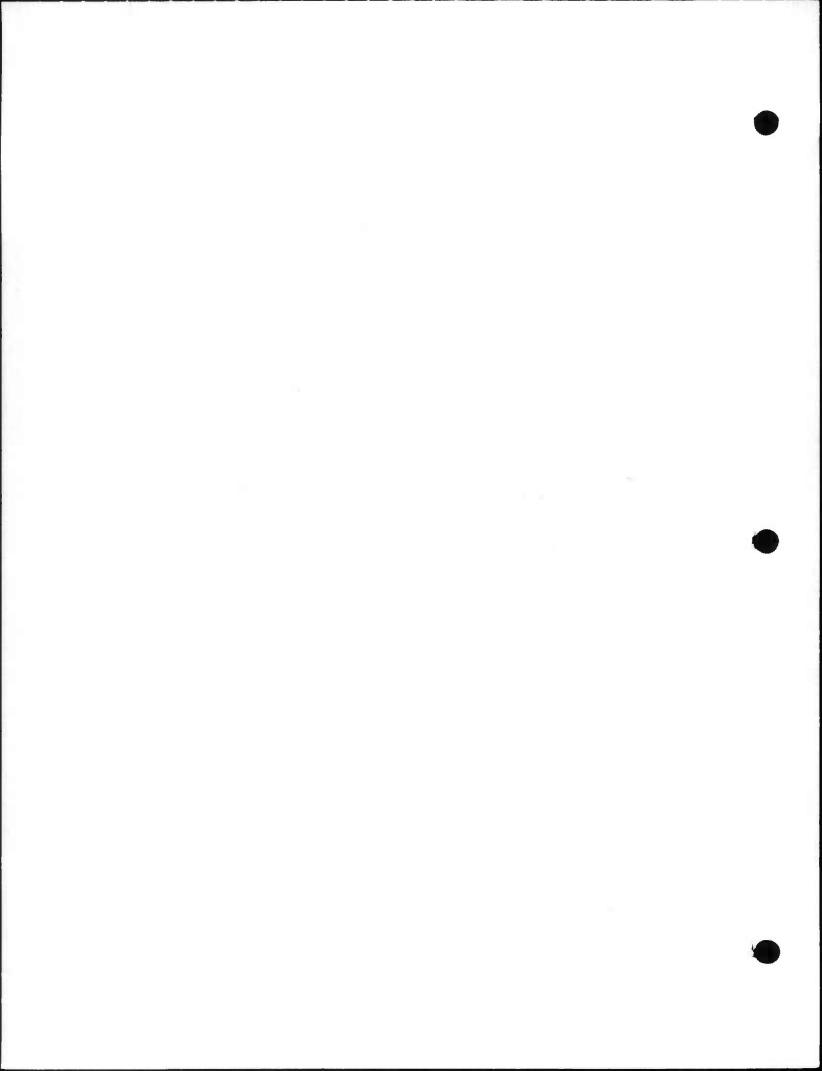
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	NEGISTRAN			CEL	111111	CAIL	IL DEV	ип.	F	EG. NO.			
- 0	1. DECEDENT'S NAME (First, Middle, L	nat)							2. DATE OF	DEATH			3. TIME OF DEATH
19	JAMES	LEW	TS		JOH	NS			June	20 DA	199	YEAR	4:00 A M
	4. SOCIAL SECURITY NUMBER	5. SEX	_	n yrs. leat bi		IF UNDER 1 YE	D IE IMP	ER 24 HRS.	7. DATE OF 6		199		PLACE (State or Foreign
	220 20 0150	XX M 2 □ F				HONTHS DA		20124	(Month, De	y, Year)	0.1	Country	y)
	220-28-9152		61	L	-				Feb. 1	0,19	34	West	t Virginia
_	9a. FACILITY NAME (If not institution, g	ive street and number)				9b. CITY, TOV	N OR LOCA	TION OF DE	ATH		9c. COU	NTY OF D	EATH
9		South St.				Fr	ederi	ck			Fr	eder:	ick
5	RESIDENCE OF DECEDEN												
DIRECTOR	10a. STATE 10b. CO			1	10c. CITY,	TOWN OR LO							10d. INSIDE CITY LIMITS?
ā	Maryland	Frederic	K			Fred	erick						TY YES 2 NO
A	10e. STREET AND NUMBER						101. ZIP CO	ĐE			10g. CIT	IZEN OF W	HAT COUNTRY?
R	701 East	South S	t.					2170	1		U	nite	d States
FUNERAL	11. MARITAL STATUS	12. WAS DECED	ENT EVER IN	IIS ARME	in .	12 WMC	DECEMBENT	OF HISBAN	IC ORIGIN? (S	a salfa Va a			
	1 Never Married 2 Married	FORCES?	TY YES	2 NO		If yes	specify Cui	oan, Mexicar	n, Puerto Ricer	n, etc.)	or 140—	Black	— American Indian, , White, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE	ewan or da rea	ITES		1 🗆	YES 2 📉 N	Specify	•			Specif	w. White
	15. DECEDENT'S		T	46 - DEOE	DENTIO	SUAL OCCUP			T				MILLE
	(Specify only highest g	rade completed)		(Give	kind of wo	rk done during	most of wor	king	166. KIN	D OF BUS	INESS/IN	DUSTRY	
ا ت	Elementary/Secondary (0-12)	College (1-4 or	5+)										
₹ I	9th			Paı	nter				Pai	ntin	g Co	ntra	ctor
COMPLETED	17. FATHER'S NAME (First, Middle, Last						16. MC	THER'S NAI	ME (First, Middl	e, Maiden S	Sumame)		
BE		Lewis		Jo	hns		E	dith	G	oodm	an		
	19a. INFORMANT'S NAME (Type/Print)			19b. N	AAILING A	DDRESS (Str	et and Numb	er or Rural R	loute Number, (City or Town	, State, Zi	Code)	
2	Judy Rice	Johns			701	East	South	St./	Frede	rick	. Md	. 2	1701
- 1	METHOD OF DISPOSITION		206			DISPOSITION		5507	DATE		_	City or Ton	
- 1	W Buriat 2 Cremation 3 1	Ramoval from Stata	came	elary, cremat	tory or othe	Memo:	of all						
	21 SIGNATURE OF FUNETAL SERVICE	LICENSES	-	Nestii	aven					rre	deri	ck, I	Maryland
- 1	ZINGIGINATURE OF PURELAL SERVICE	A C	\sim			22. NAM	AND ADDR	ESS OF FAC	Sta	uffe	r Fu	nera	l Home
	DIII.	M, C	70	10		162	1 000	ssumt					Md.21702
	23. PART I. Enter the diseases,	or complications t	hat caused	the death	n. Do no								
1	ahock, or heart falls	re. List only one c	ause on as	ch iine.		t dividit ting	mode of d	ynig, auci	as cardioc	Of Teapir	atory ar	reat,	Approximate interval Between
	iMMEDIATE CAUSE (Finel disease or condition	1			W.		m 1	/					Onset and Death
	resulting in death)	. Con	gerfu	u 1	Mea	Ur	Hau	lure					Gened were
	The state of the s	DUE	OR AS A	CONSEQUE	ENCE OF):	cheu	4	,					
z	**************************************	- 60	rona	lu	a	Hele	oll	rear	1				securel you.
CERTIFICATION	Sequantially list conditions, if any, leading to immediate	DUE 1	TO (OR AS A										
3	cause. Entar UNDERLYING	. 9	thel	mil	cro-	w.							Heural yrs
Ē	CAUSE (Disease or Injury that initiated events	DUE	TO (OR AS A	CONSEQUE	ENCE OF):								0
E	reaulting in death) LAST	10											
8													
A	PART ii. Other aignificent cond	tions contributing	to deeth bu	it not resi	uiting in	the underi	Ing cause	given in i	Part I. 24e	. WAS AN A		24b.	WERE AUTOPSY FINDINGS
EDICAL	COVD									YES 2	2		AVAILABLE PRIOR TO COMPLETION OF CAUSE
			_						_ ' '	123 8			DF DEATH?
Σ	DID TOBACCO USE CO	NITDIRI ITE TO C	ALISE OF	E DEATH	I VEC	T NO		CERTAIN	1.170				1 TYES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICA							CEKIAIN	и				
2	EXAMINER?	HOSPITAL:		O. PLACE C	- ((Check only o		,					
YS	1 TES 2 NO	1 Inpatient 2	☐ ER/Outpa	ntient 3 🗆	DOA 4	☐ Nursing I	lome 5	Residence (6 Other (Sp	ecify)			
포	27. MANNER OF DEATH	28a. DATE (OF INJURY	2	8b. TIME		INJURY AT WORK?		26d. DEŞCRI	E HOW IN	JURY OC	CURED	
	1 Natural 5 Pending				-			□ NO					
BY	2 Cut-td-	26s. PLACE	OF INJURY	At home,	, farm, str	eet, factory, c	ffica		28f. LOCATIO	N (Street ar	nd Numbe	or Runt A	oute Number
	4 Homicide 6 Could not determine	Dulidin	g, atc. (Specif	fy)						wn, State)			
<u> </u>	29a. CERTIFIER										-		
릴	(Check only CEHTIFYING P	YSICIAN: To the best											
COMPLET	one) 2 MEDICAL EXAM	AINER: On the besis of	axamination	and/or Inve	etigation,	In my opinio	n, death occ	ured at the t	lime, data and	place, and	dua to ti	na cause(a)	and manner as stated.
	296. SIGNATURE AND TITLE OF CERT	FIER					29c I I	CENSE NUM	RFO		20d DAT	E SIGNED	(Month, Day, Year)
B	1111000	1		mi	0				1.72				
2	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED OF	HISE OF DEA	-		helmth.	ות	3063			J	une 2	21, 1995
. 1								, =					
	Dr. Abdul	Majeed, M	.D. /	801	Toll	House	Ave.	Fre	derick	,Mar	ylan	d 21	1701
	JUN 2 3 19	OF 32. REGIST	RARIS SIGNA	TURE	0.0								
	PI G 2 MIII.	95 Julia	- william	AN' NON	della								1



DIVISION OF VITAL RECORDS, P.O. BOX 68760

HOSPITAL

295. SIGNATURE AND TITLESOF CERTIFIER

JUN 16 1995

30. NAME AND ADDRESS OF PERSON WHD COMPLETED CAUSE DF DEATH (ITEM 27) (Type, Print)

2. REGISTRAP'S SIGNATURE

BE

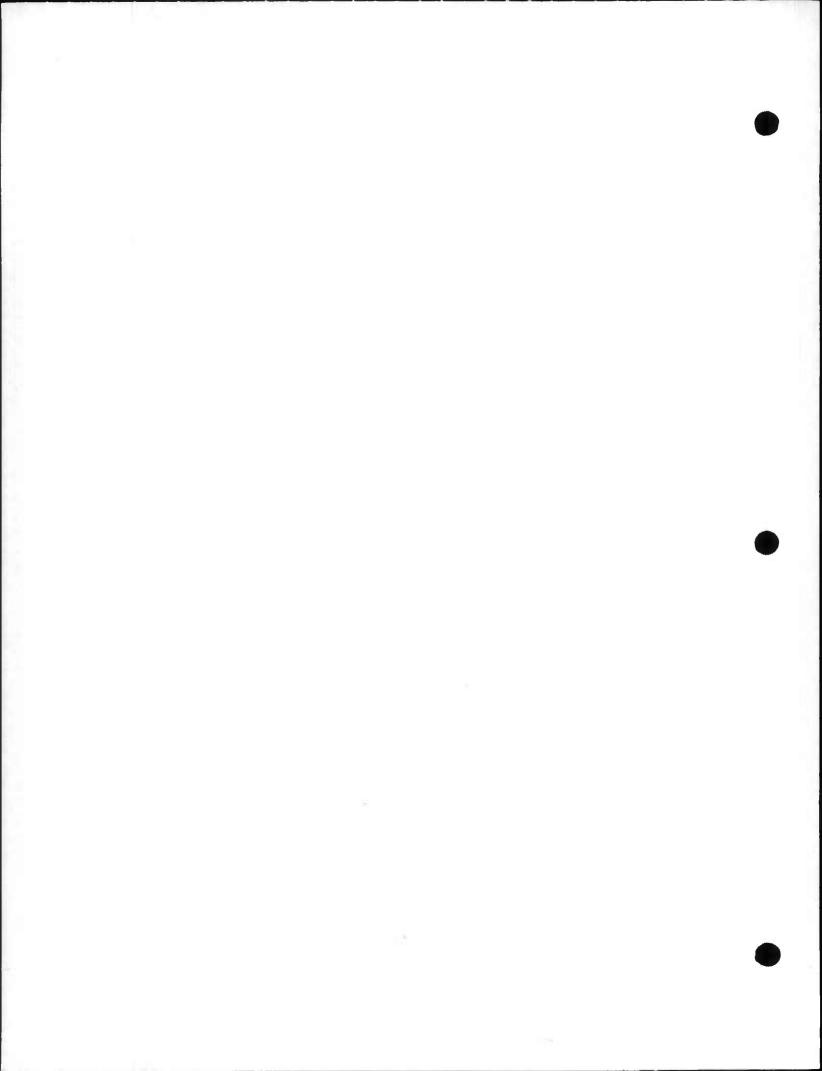
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH JOHNSON MILDRED **JEANETTE** Ohnso 199 915 June 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthdey IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign (Month, Day, Year MAR. 5, HOURS 1 M 2 X F 222-14-6447 71 YRS. DELAWARE 1924 Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY WICOMICO MD PITTSVILLE 1 YES 2 X NO permit. FUNERAL 10e. STREET AND NUMBER 10g, CITIZEN OF WHAT COUNTRY? n and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit to burlal, cremation, or removal. 35055 MOUNT HEBRON ROAD 21850 USA retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES ... 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 X NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Narried BY 3 Widowed 4 Divorced Specify: WHITE COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Sp Elementary/Secondary (0-12) College (1-4 or 5+) 4 HOMEMAKER OWN HOME 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at BE (McFADDEN SMITH LUCY JONES 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 J. RICHARD JOHNSON 35055 MOUNT HERMON RD., PITTSVILLE, MD 21850 20s. METHOD OF DISPOSITION
1 M Burlel 2 Cremation 3 Removal from State
4 Donetton 6 Other (Specific Раде 6 тау be 9 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- Cify or Town, State DATE must POWELLVILLE CEMETERY 6/17 POWELLVILLE, MD examiner 21. SIGNATURE GE-FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY hours after death. HASTINGS FUNERAL HOME, SELBYVILLE, medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final **Onset and Death** the disease or condition_ reaulting in death) requires that the death certificate be executed with DUE TO (OR AS A CONSEQUENCE OF traumatic 4070 CERTIFICATION Sequantially list conditions, TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury signed by the attending physician Health and Mental Hygiene prior to other DUE-TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 ear-PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO amy COMPLETION DF CAUSE 1 TYES 2 NO 1 TYES 2 ND has been Dept. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: MP 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) OR ATTENDING PHYSICIAN: The the State tem HOSPITAL: OTHER: 1 YES 2 NO 1 Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 26s. DATE OF INJURY this c 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked. 1 Natural М 1 YES 2 NO After 1 death BY 2 Accident 28e. PLACE DF INJURY — At home, farm, street, tectory, office building, atc. (Specify) 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: A 8 Could not be COMPLETED 4 Homicide 29s. CERTIFIER
1 DEERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. FUNERAL within 72 I 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner se stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 11

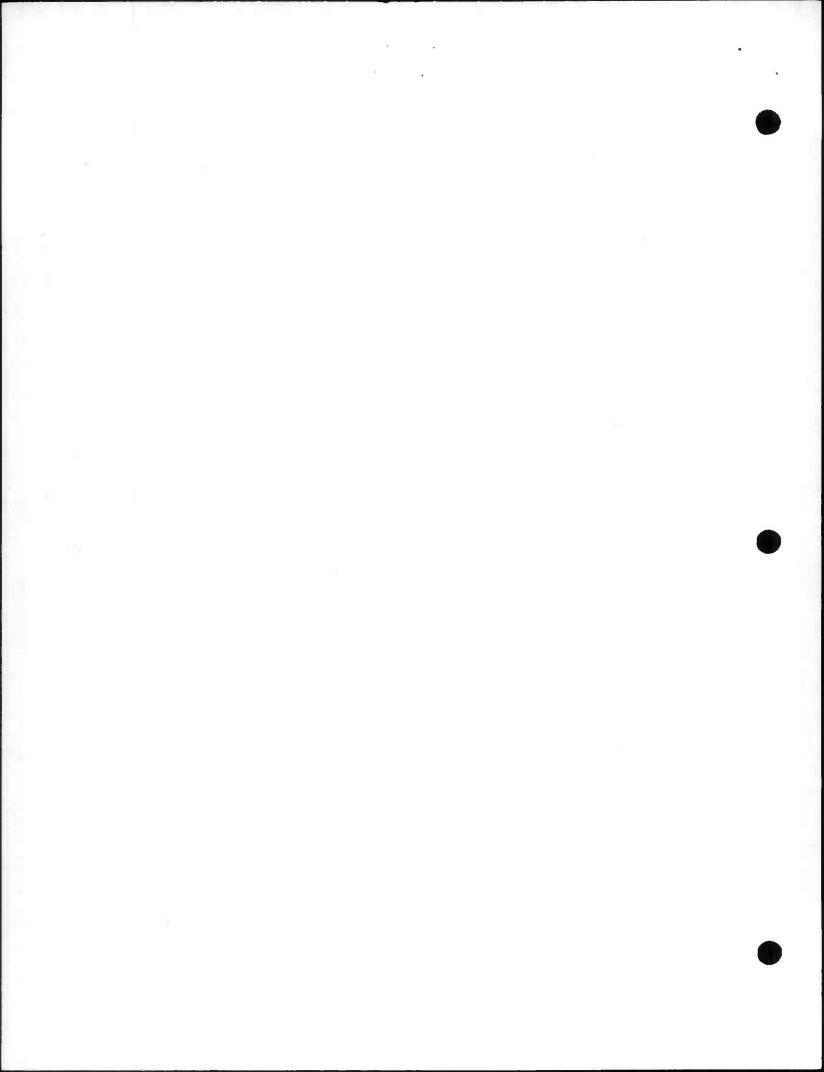
29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year)



BALLIMORE, MAK	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should	
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DIVISION OF VITAL RECORDS, P.O. BOX 88760	9NIC	After	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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_		1 - FOR STATE REGISTRAR	STATE OF MARYL				HEALTH AND F DEATH	MENTAL HYGIEN REG. NO		
	1	1. DECEDENT'S NAME (First, Middle, Last)	MAGDALENE			Jon	eS	A	199	VEAR 0.335 M
				(In yrs. lasi	birthday) #	UNDER 1 YEAR	IF UNDER 24 HRS.	DUNE 21	/	
	ĺ	2/3-/8-4756 1 90. FACILITY NAME (If not institution, give atree)	□ M 2 X F	74	YRS.	NTHS DAYS	HOURS MIN.	MAY 8, 19	21	8. BIRTHPLACE (State or Foreign Country)
OR O		99. FACILITY NAME (If not institution, give atreet PENINSULA REGIONA)		ENTE			OR LOCATION OF D	EATH	9c. COU	NTY OF DEATH ICOMICO
급		RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY			10c CITY TO	OWN OR LOC	ATION			
DIRECTOR	- 14	MD. WORCE	STER			W HI	LL			10d. INSIDE CITY LIMITS? 1 YES 2 X NO
FUNERAL		104. STREET AND NUMBER	0040				101. ZIP CODE			ZEN OF WHAT COUNTRY?
1 2		4342 RED HOUSE	RUAD 2. WAS DECEDENT EVER I	MII S.ADI	MED	12 440 0	21863	NIC GRIGIN? (Specify Yes		S.A.
B	ı	1 Never Merried 2 Merried 3 Widowed 4 Diverced	FORCES? 1 YES	3/ N	0	If yes,		an, Puerlo Rican, etc.)	or No—	14. RACE — American Indian, Black, White, etc. Specify: WHITE
ETED	ı	15. DECEDENT'S EDUCAT (Specify only highest grade con	ION noleted)	16a. DE0	CEDENT'S USL	IAL OCCUPA	TIÓN	16b. KIND OF BUS	SINESS/IND	DUSTRY
급			Coffege (1-4 or 5+)	life.	OKKEE	tired.)	nost of working	SUPPL	y 57	TORE
Once. COMPL		17. FATHER'S NAME (First, Middle, Last)						AME (First, Middle, Malden		
BE at		OLIN CARMEAN						TTIE MATT		
5		190. INFORMANT'S NAME (Type/Print) LEE C. JONES						Route Number, City or Tow		LL, MD. 21863
25 25	ı	20a METNOD OF DISPOSITION 1 A Burlel 2 Cremetton 3 Removal	I from State	PLACEA	ND DATE OF D	SPOSITION /	Name of	DATE 20c. LO	CATION	City or Town, State
Ē		4 Donetion 5 Other (Specify)		AZE	Sory CEM				W H1	ILL, MD.
i examiner must be notified at once. TO BE COM	21. SIGNATURE OF PUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY BOUNDS FUNERAL HOME, SALISBURY, MD. 26. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, Approximate									
event, the medical		38. PART I. Enter the diseases, or com- shock, or heart feliure. List IMMEDIATE CAUSE (Finel disease or condition resulting in death)	plications that caused on e	ech ilne.	mes	enter the n	node of dylng, suc	ch as cardisc or respi	ratory arr	Approximata interval Between Onset and Death
ERTIFICATION		Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING cause. Enter UNDERLYING cause to injury that initiated events resulting in deeth) LAST	DUE TO (OH AS A	DO	UENCE OF):	TW	Syndn Syndn	pme		200 v2 200 v2
CE		d	- 1							
SCA I		PART II. Other eignificent conditions c	Trusus.	ut not re	eaulting in th	ne underlyi	ng ceuse given in	Part i. 24s. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
2 ⊆		DID TOPACCO LISE CONTRIB	LITE TO CALICE O	E DEAT	THE WEST		The same			1 TES 2 NO
3 3		DID TOBACCO USE CONTRIB			OF DEATH (C			иП		
SICI/			OSPITAL: Inpetient 2 ER/Outp		01	HER:	me 5 🗆 Residence	8 C Other (Conside)		
BY PHYS		27. MANNER OF DEATN 1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)		28b. TIME OF	28c. II	JURY AT	28d. DESCRIBE NOW II	NJURY OCC	CURED
0 2		2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, atc. (Spec	— At hon	ne, ferm, stree		YES 2 NO	281. LOCATION (Street a City or Town, State)	nd Number	or Rural Route Number,
BE COMPLETE		290. CERTIFIER 1 CERTIFYING PHYSICIAN								
S S		one) 2 MEDICAL EXAMINER: 0	on the beels of examination	n end/or In	westigation, in	my opinion,	death occured at the	time, date and place, en	d due to the	e cause(s) end manner es stated.
BEC	1	29b. SIGNATURE AND TITLE OF CERTIFIER	~				29c. LICENSE NUI		29d. D.TE	SIGNED (Month, Day, Year)
2	#	TO DAME AND APPRESS OF PERSON WAYS OF	4:18				D198	22	6	21/25
	*	30. NAME AND ADDRESS OF PERSON WHO CO		-			. ~	0816	1	



4. SOCIAL SECURITY NUMBER

9a. FACILITY NAME (If not institution, give street and number,

5600 54th AVENUE #111

10b. COUNTY

15. DECEDENT'S EDUCATION

DOCTORS HOSPITAL

RESIDENCE OF DECEDENT

1 Never Married 2 Married

(Specify Elementary/Secondary (0-12)

17. FATNER'S NAME (First, Middle, Last)

19a. INFORMANT'S NAME (Type/Print)

WILLIE R. HAMER

4 Donation 5 Other (Specify)

20a. METHOD OF DISPOSITION
1 Å Burtal 2 Cremation 3 Removal from Stale

Kevin H.

23 1995

31. DATE FILED (Month, Day, Year)

JOHN HAMER

3 Widowed 4 Divorced

579-32-8051

MARYLAND

10e. STREET AND NUMBER

Laura Elizabeth Jones

5. SEX

PRINCE GEORGES

IF UNDER 1 YEAR

LANHAM

10c. CITY, TOWN OR LOCATION

HYATTSVILLE

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)

20b. PLACE AND DATE OF DISPOSITION (Name of

Scott 1725 Belle Wint Dr., Greenbelt, MD

HARMONY MEMORIAL PARK

ADMINISTRATIVE ASST.

HOURS

10f. ZIP CODE

20781

D38534

6. AGE (In yrs. last birthday)

67

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 THO IF YES, GIVE WAR OR DATES

College (1-4 or 5+)

permit. Pages 1, 2, 3 should

DIRECTOR

FUNERAL

BY

COMPLETED

BE

2

Ħ

notified

must be

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BE

2

					0/2						
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE			FACILITY						
	► (Blee X	Kinch	M859	ALEXANDER S	. POPE	F					
-	02 PART I Season by divine	000		5538 Marlbo	ro Pike	٠,					
	ehock, or heart failure.	complications that caused the List only one cause on each li	death. Do not o ine.	enter the mode of dying, s	uch as cardie	c o					
	iMMEDIATE CAUSE (Final disease or condition reaulting in death)										
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSEQUENCE OF):									
ERTIFIC	CAUSE (Disease or injury that initiated events resulting in death) LAST										
	PART II. Other significent condition	s contributing to deeth but no	t reaulting in th	e underlying cause given	in Part I. 24	in, i					
ă					1						
¥											
ż	DID TOBACCO USE CONTI	RIBUTE TO CAUSE OF DE	ATH YES	□ NO □ UNCERTA	IN 🖾						
8	25. WAS CASE REFERRED TO MEDICAL										
Sic	1 YES 2 KNO	1 Inpatient 2 ER/Outpatient			8 Other (S	Spec					
32 0	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	M 1 YES 2 NO	28d. DESCRIBE						
	3 Suicide 8 Could not be 4 Homicide detarmined										
	FTED BY PHYSICIAN: MEDICAL CERTIFICATION	23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events reaulting in death) LAST PART II. Other significent condition DID TOBACCO USE CONTI 25. Was CASE REFERRED TO MEDICAL EXAMINER? 1	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DIE TO (OR AS A CONSTITUTE	23. PART I. Enter the diseases, or complications that caused the death. Do not dehock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) BUE TO (OR AS A CONSEQUENCE OF): LUNG CANCET BUE TO (OR AS A CONSEQUENCE OF): LUNG CANCET BUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, so shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition reaulting in death) But TO (OR AS A CONSEQUENCE OF): Lung Cancer Due TO (OR AS A CONSEQUENCE OF): Lung Cancer Due TO (OR AS A CONSEQUENCE OF): Compared the initiated events reaulting in death) LAST Due TO (OR AS A CONSEQUENCE OF):	M859 ALEXANDER S. POPE 5538 Marlboro Pike 6000K, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition reaulting in death)					

32, REGISTRAR'S SIGNATURE

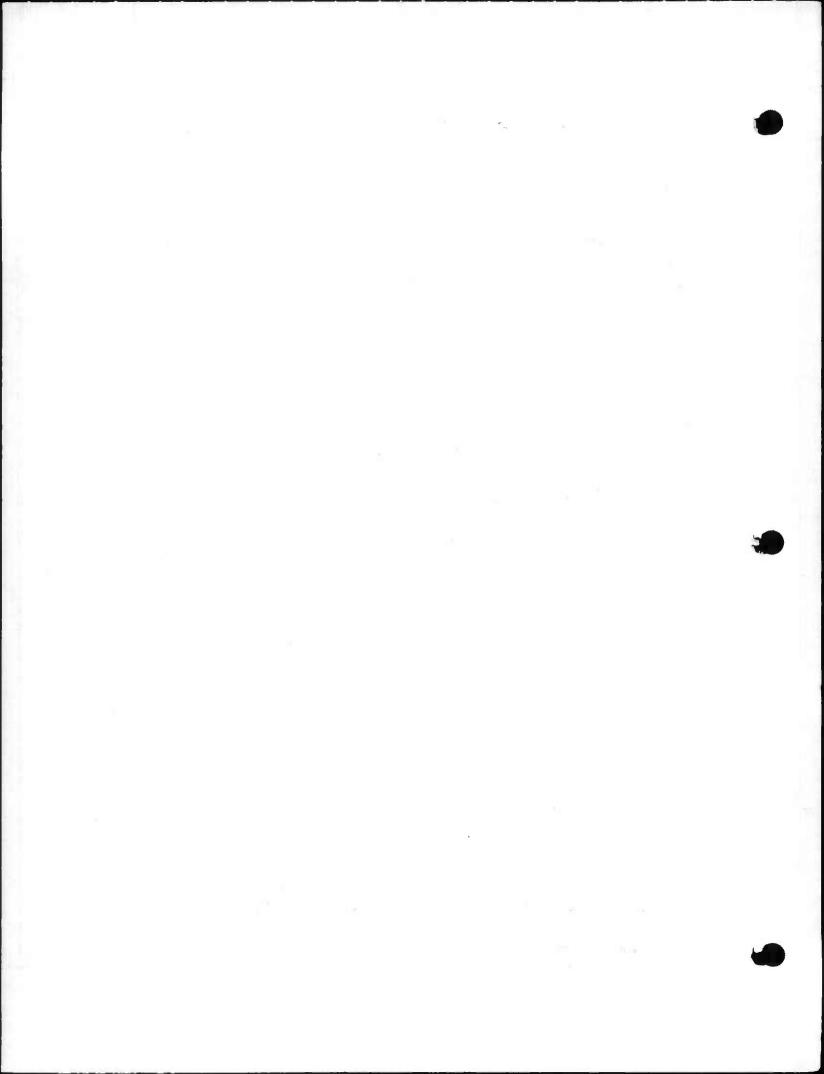
whi Davelson Randall

2. DATE OF DEATH 3. TIME OF DEATH DAY 1995 June 17, 6:17A 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) (Month, Day, Year)
JUL 11, 1927 North Carolina 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH PRINCE GEORGES 10d. INSIDE CITY 1 X YES 2 NO 10g. CITIZEN OF WNAT COUNTRY? United States 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto Rican, etc.)

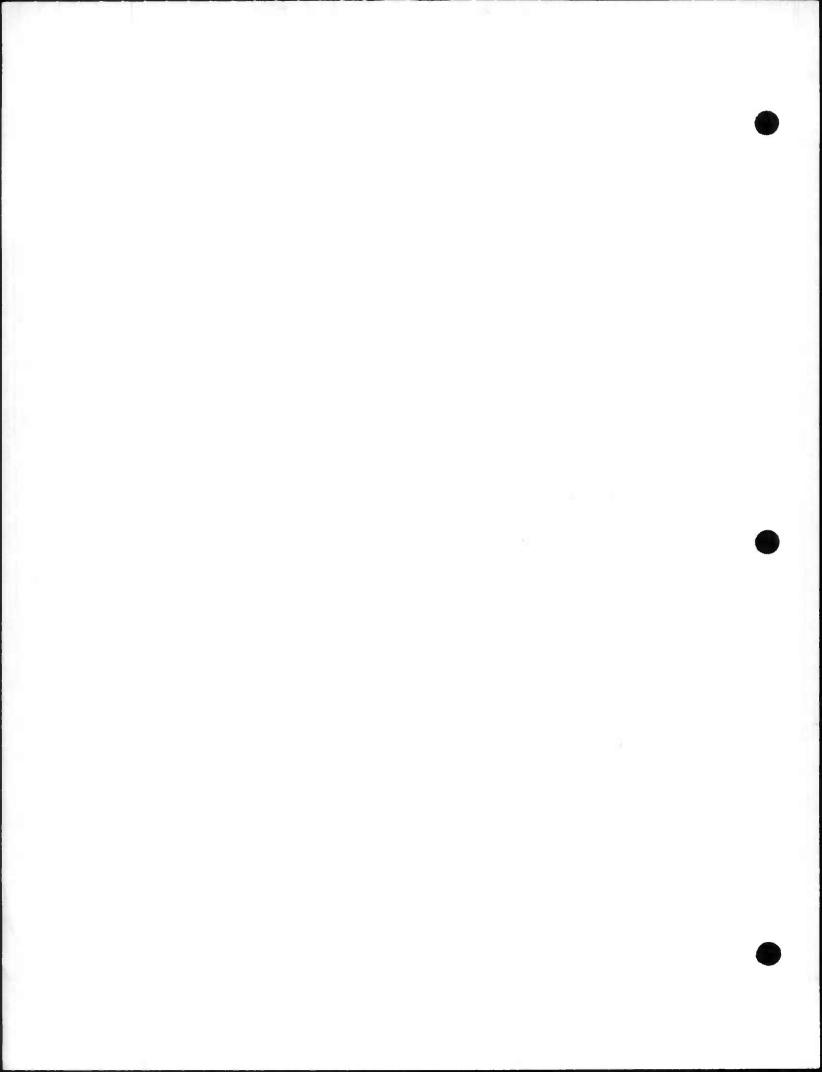
1 YES 2 NO Specify: Specify: Specify: BLACK 16b. KIND OF BUSINESS/INDUSTRY U.S. GOVERNMENT 16. MOTHER'S NAME (First, Middle, Maiden Sumame) FLORENCE RAY 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4725 BAMBERT ROAD, COPER, SOUTH CAROLINA 29038 DATE 20c. LOCATION - City or Town, Sieta 6/24 LANDOVER, MARYLAND 22. NAME AND ADDRESS OF FACILITY ALEXANDER S. POPE FUNERAL HOMES 5538 Marlboro Pike, Forestville, MD 20747 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or reepiratory arrest, interval Batween **Onset and Death** 1 hour 2 years MAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE YES 2 NO DF DEATN? 1 YES 2 NO NOW INJURY OCCURED (Street and Number or Rural Route Number nd manner as stated. eca, and due to the cause(a) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

▶ June 20, 1995

20770



		1 - FOR STATE REGISTRAR	STATE OF MARYLA		RTMENT OF H		IENTAL HYGIE!	_			
		1. DECEDENT'S NAME (First, Middle, Last)	CHARLIE JACI	KSON			2. DATE OF DEATH MONTH		YEAR	TIME OF DEA	тн Д м
1/2		14 L 3000	. SEX 6. AGE (III	yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) JUN 28, 1	1 8		ACE (State or F	oreign
3 should	E	98. FACILITY NAME (If not institution, give street PRINCE GEORGES HOS	ALCO CONTRACTOR OF THE PARTY OF	R	96. CITY, TOWN C	OR LOCATION OF DEA	TH	9c. COUNT			
1. 2.	CTO	RESIDENCE OF DECEDENT	TITAL CENTE					TEKTING	E GE	JRGES	
permit. Pages	DIRE	NA NA			Y, TOWN OR LOCAT	, D.C.				d. INSIDE CITY LIMITS? YES 2 [
sit peri	HAL	1/. 26 MACCACHTICEPPEC	AVE G E		10	I, ZIP CODE		2.00		T COUNTRY?	
020 physician. burial-transit p	FUNER	1426 MASSACHUSETTS 11. MARITAL STATUS 12	. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC	20003 ENDENT OF HISPANI	C ORIGIN? (Specify Ye			TATES American Indi	lan.
215-0020 attending physic use as the burial	BY	1 Never Married 2XXMerried 3 Widowed 4 Divorced	FORCES? 1 X YES IF YES, GIVE WAR OR OA 1952 - 1954		If yes, sp	ecify Cuban, Maxican 2 XNO Specify:			Specify: BLA	hits, etc.	
or atter	ETED	15. DECEDENT'S EDUCATI (Specify only highest grade con			USUAL OCCUPATION		16b. KIND OF BL	JSINESS/INDUS	STRY		
# 5	PLE	Elementary/Secondary (0-12)	College (1-4 or 5 +)	AUTO ME			GAS CO	MPANY			
AND the hospit detached	COMPL	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAM	E (First, Middle, Malder	n Sumame)			
# 8 E	l m	JOHN JACKSON				CLARA H					
MAR retained 5 should notified	7	196. INFORMANT'S NAME (Type/Print) LILLIAN JACKSON	(WIFE)				Wash.,D.C				
E Sop E		20g. METHOD OF DISPOSITION	20b.		OF DISPOSITION (Ne			OCATION — CH		State	
Page 6 ma al director, p		1 🖄 Buris! 2 Cremation 3 Removal 4 Donation 6 Other (Specify)	Wa	shington	n Nation	al Cem.		ITLAND			
BALTIMO after death. Page 6 by the funeral directo moval. Ical examiner mu		21. SIGNATURE OF JUNETIAL SERVICE LICEN	9 0	MOEO		ANDER S	UTY POPE FUNE	RAI. HO	MES		
the fur dead oval.		" alleg X "1	NID _	M859	5538	Mar1boro	pike, Fo	restvi	11e.1	Md 207	47
in in		23. PART I. Enter tilla diseases, or con shock, or haart fallure. Liat	pilcatida that caused t only one cause on as	tha daath. Do i ch lina.	not antar tha mo	da of dying, such	as cardiac or resp	oiratory arres	it,	Approxim	Between
rithin 24 ho bletely filled remation, or		iMMEDIATE CAUSE (Final disease or condition resulting in death)	Inferior OUE TO (OR AS A	Vena	Cour	1 This	on 60sc	` 5		2 wee	
executed vand composition of purial, composition matter every	z		Renall							2 Wee	LVS
be exection and or to be aumain	ERTIFICATION	Sequentially list conditions, If any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE O	F):						-1-
ificate physical price p	FIC	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	F):						
F. Certi	E	resulting in death) LAST									
the att Menta	O	PART II. Other significant conditions c	ontributing to death bu	it not resulting	in the underiving	g cause given in P	art i. 24s. WAS AF	N AUTOPSY	24b WE	RE AUTOPSY F	PARIMOS
that the stand lith and 15							RMED?	AM	MPLETION OF	TO	
requires the seen signed of Health shows and	ME							7		DEATH?	NO
i law n nas bee Dept. 23 s	A N	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL			TH (Check only one)	UNCERTAIN	M				
VIIAL AN: The law inficate has State Dep		EXAMINER?	OSPITAL:		OTHER:	ne 5 🗆 Rasidenca 6	Other (Specify)				
HYSICIA his certif with the	>	27. MANNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year)	28b. TIM	IE OF 28c. INJ		28d. DESCRIBE HOW	INJURY OCCU	RED		
ING PHYSI (fter this o eath with 1	BY	1 Netural 5 Pending 2 Accident Investigation			M 1 🗆 1	YES 2 NO					
TTEND TTOR: A after d	TED	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY - building, etc. (Specif	— At home, lerm, s	street, factory, offic	•	261. LOCATION (Street City or Town, State	and Number or	Rurai Route	Number,	
Z Z Z =	MPL	29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAL EXAMINER: C								d manner ss s	stated.
THE HOSPI THE FUNEF filed within PORTANT:	BE C	PHARMATURE AND TITLE OF CENTIFIER	1 0.0			29c. LICENSE NUME	BER	29d. DATE 9	IGNED (Mo	onth, Day, Year)	
5 5 3 X		38. HAME AND ADDRESS OF PERSON WHO C	DEFET ED CAUSE OF DEA	TH (ITEM 27) (3	Print)	1763	51	I G	120	195	
3)		James S. Chesl	CY Jr M.D.	77000	old Bra	ch Ave	Clipton,	Md ?	202	35	
		"JUN 23 1995 Au	32. REGISTRAR'S SONA	TURE							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Oept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Nem 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

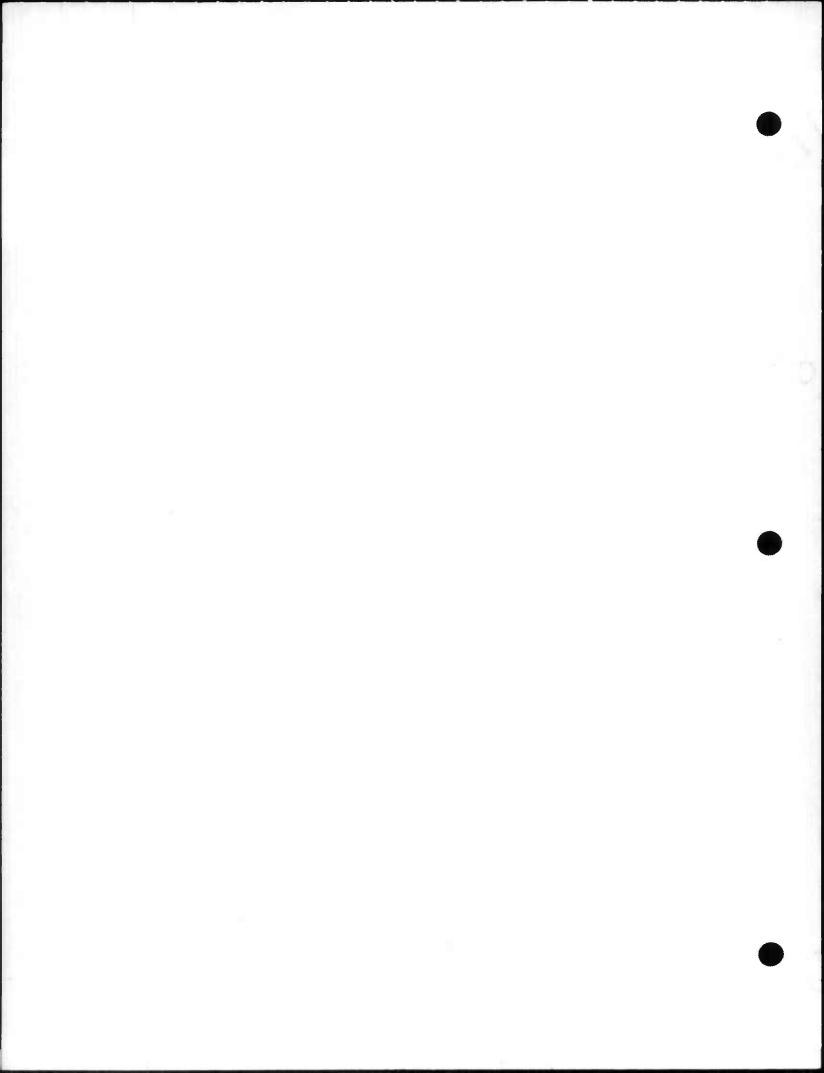
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68769

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	REGISTRAR		CERTIF	ICALE C	F DEATH	F	REG. NO.		
	1. OECEDENT'S NAME (First, Middle, Last)					2. DATE OF MONTH	DEATH	YEAR	3. TIME OF DEATH
	RIII	BY B. JON	ES-BELL			TINE	-		1.43 AM
	4. SOCIAL SECURITY NUMBER		GE (in yrs. lest birthday)	IF UNDER 1 YEA		7. DATE OF I	BIRTH		HPLACE (State or Foreign
	577-48-3113	1 M 2 F	59 YRS.	MONTHS DAY	B HOURS MIN.		4.1936		RYLAND
	9a. FACILITY NAME (If not institution, give s	street and number)		9b. CITY, TOW	N OR LOCATION OF D			OUNTY OF	
DIRECTOR	PRINCE GEORGE	S HOSPIT	AL	CHEV	ERLY		PR	INCE	GEORGE'S
띮	10a. STATE 10b. COUNT			TY, TOWN OR LO	CATION				10d, INSIDE CITY
5	MARYLAND PRI	NCE GEORG	CRIC	YATTSV	7777				LIMITS?
占	10e. STREET AND NUMBER	CNC S. IS SORI	36 5 1 1	YATTIS	101. ZIP CODE		10g. C	ITIZEN OF	WHAT COUNTRY?
EB.	3517 TOLEDO TE	AN EDVOOR			2070	0			
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVI	ER IN U.S. ARMEO	13. WAS	2078 DECENDENT OF HISPA		pecify Yes or No-	II S	E — American Indian, k, Whita, atc.
	1 Never Married 2 Married	FORCES? 1 1	PR DATES A		specify Cuben, Mexic (ES 2 The NO Speci		n, etc.)	Spec	
ВУ	3 Widowed 4 Divorced				X				ACK
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16s. DECEDENT'S (Give kind of	work done during	ATION most of working	16b. KIN	D OF BUSINESS/I	NDUSTRY	
Ë	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	ise retired.)	W 125.5 (C.174)				
ΜĀ	9+h		HOUSE	KEEPER		<u> </u>	PRIVATE		
	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S N	AME (First, Middle	le, Maiden Surname,)	
B		NOTX			EVA	WASHI	NGTON		
2	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Stre	et and Number or Rural	Route Number, (City or Town, State, .	Zip Code)	20782
	DWIGHT H REI	I. (HUSBA)			DO TERR				
	20a. METHOD OF OISPOSITION 1 Burlat 2 Cremation 3 Ram	oval from State	20b. PLACE AND OATE cometery, cremetory or o	other place)		DATE	20c. LOCATION -		·
	4 ⚠ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC	CENCEE	HARMONY	MEMOR	TAL PK				
	A /	7	1/ .		AND ADDRESS OF F	JC			NKINS INC
	Delna 7	n. your	Deno	716	KENNED	Y ST.,	N.W.	WASH	D.C. 20
	23. PART I. Enter the diseeses, or shock, or heart failure.	complications that cau	sed the death. Do	not enter the	mode of dying, su	ch es cerdiec	or respiratory	errest,	Approximats
	IMMEDIATE CAUSE (Fine)	Liet bnly one ceuse o	n esch line.						Onset and Death
	disease or condition	CARCINO	MA OF ES	орнаси	S WITH	ивфасц	PACEC		lyr.
- 1			AS A CONSEQUENCE C		O WALLE	1111101	.110110		- y
Z	Sequentially list conditions,	BILATERA	AL PNEUM	ONIA					10 days
CERTIFICATION	if any, leading to immediate	DUE TO (OR /	AS A CONSEQUENCE O	F):					
2	CAUSE (Disease or injury	SEIZURES	3	_					10 days
Ē	that initiated events resulting in desth) LAST	DUE TO (QR)	AS A CONSEQUENCE O	F):					
8		d							
	PART II. Other significant condition	s contributing to deal	th but not resulting	in the underly	ring ceuse given in	Pert i. 24s	. WAS AN AUTOPS	Y 24t	. WERE AUTOPSY FINDINGS
EDICAL						11	PERFORMED?		AMAILABLE PRIOR TO COMPLETION OF CAUSE
							Mes z No		OF DEATH?
Σ	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH Y	ES 🗆 NO	☐ UNCERTAI	N M			1 X YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEA			💯			
Sign	EXAMINER?	HOSPITAL:	Outpatient 3 DOA	OTHER:	lome 5 🗆 Rasidenca	6 Other (So	ecifu)		
È I	27. MANNER OF OEATH	26a. DATE OF INJU		E OF 28c.	INJURY AT		BE HOW INJURY O	CCURED	
ВУР	1 Netural 5 Pending	(Month, Day, Ye	III)		WORK?				
	2 Accident Investigation 3 Suicide 6 Could not ba	26s. PLACE QF INJ building, atc. (URY - At home, farm,	street, factory, o	ffica	261. LOCATIO	N (Street and Numb	er or Rural I	Route Number,
門	4 Homicide detarmined	ounding, arc. (Specny)			City or To	wn, State)		
COMPLETED	29a. CERTIFIER (Check only 1 CERTIFYING PHYSI	CIAN: To the best of my k	nowledge, death accum	ed at the time of	ata and place, and du-	to the sevects	and manner as at	lated	
ž I		R: On the besis of exemin							and manner as stated
- 11	29b. SIGNATURE AND TITLE OF CERTIFIER								
8	num				29c. LICENSE NU D 436		29d. D/	TE SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF	DEATH (ITEM 27) /5	Deint)	17426	~ -	(10	171
-	William Boyce	M.D. 30	101 Hosp	ital D	rive, Ch	everl	y. Md.	207	85
	JUN 21 1995	32. REGISTRAR'S S	Let						
- 1	- 1000 / ···								



DIVISION OF VITAL RECORDS, P.O. BOX 68760

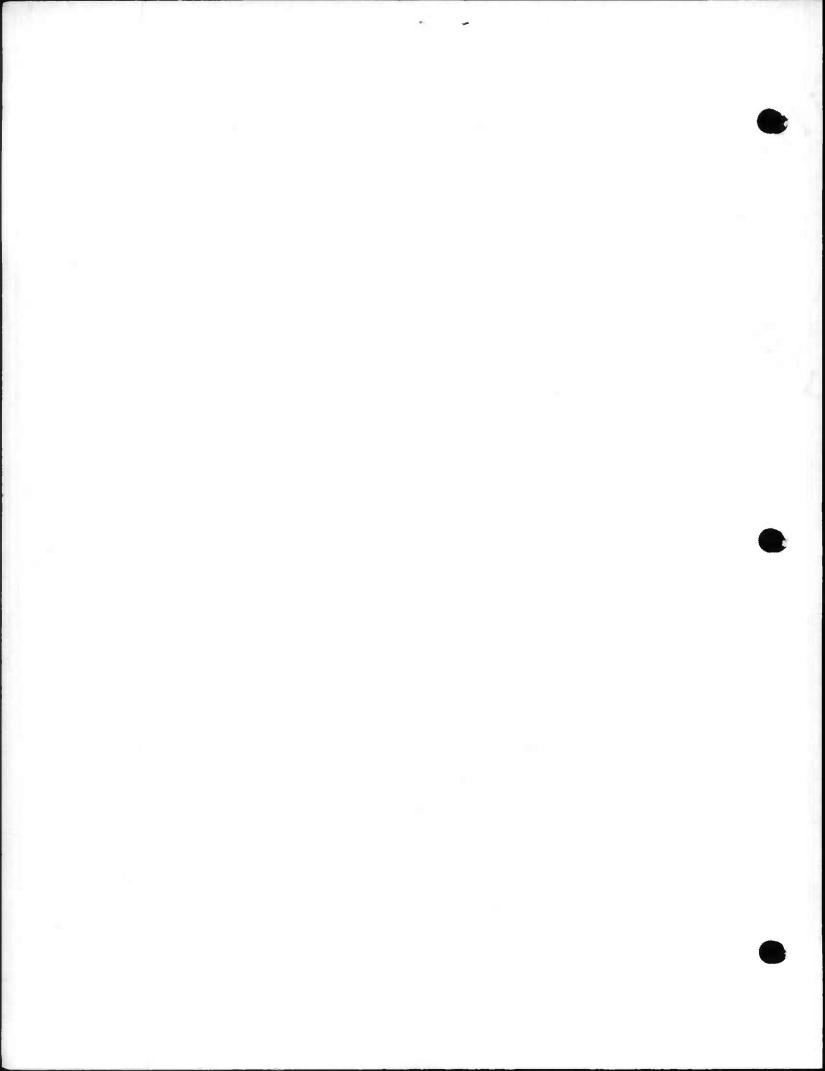
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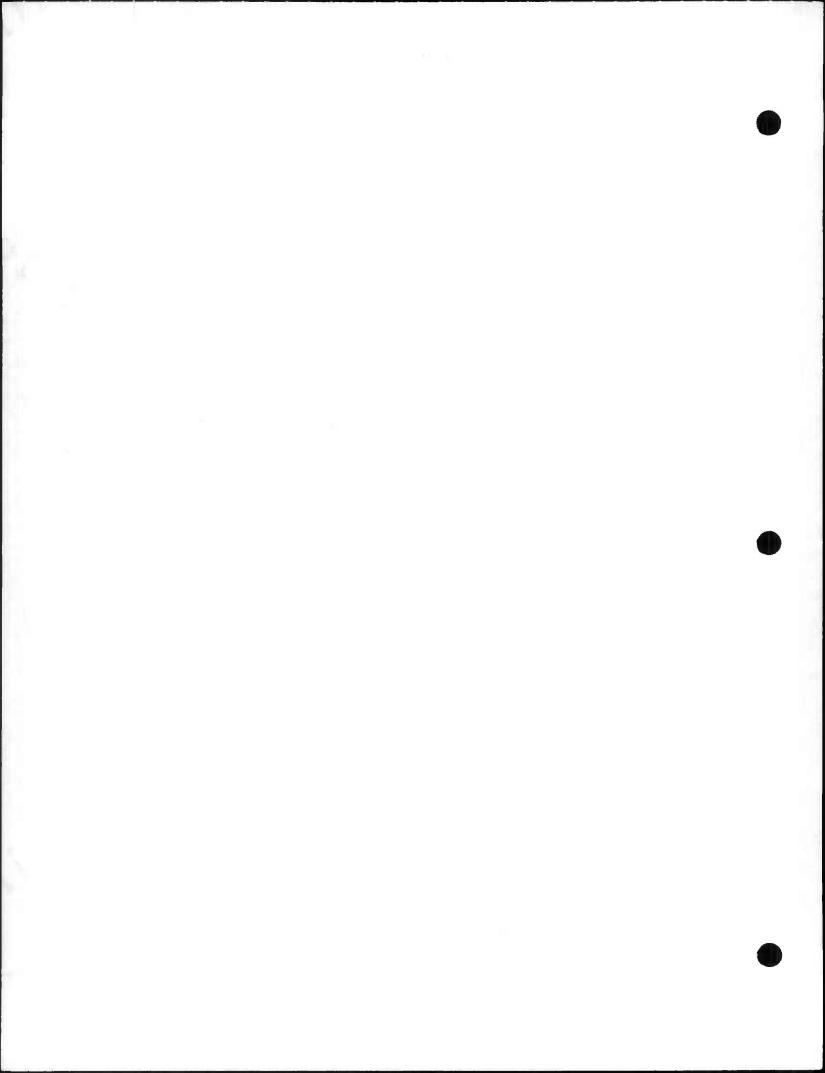
1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

	REGISTRAR		CE	RTIFIC	CATE OF	DEATH	R	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	1-00					2. DATE OF I	DEATH	, ,	YEAR	3. TIME OF DEATH
	KATHRYN K	KREI	BOHI	\sim			140	1 2		95	2,40 Am
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. las		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF E	HRTH		B. BIRTHI	PLACE (State or Foreign
	075-26-9868	1 🗌 M 2 💢 F	87	YRS.	ONTHS DAYS	HOURS MIN.	Apr 5	, 190	8	Vir	ginia
	9a. FACILITY NAME (If not institution, give a	treet and number)		- 1	b. CITY, TOWN	OR LOCATION OF DE			9c. COUNT		
S	Howard County Ger	neral Hosp	ital		Colum	bia			Hov	vard	
5	RESIDENCE OF DECEDENT										
DIRECTOR	10a. STATE 10b. COUNTY			10c. CITY,	TOWN OR LOCA						10d. INSIDE CITY UMITS?
		vard			Columb	ıa					1 TYES 2 NO
¥.	104. STREET AND NUMBER				10	. ZIP CODE					HAT COUNTRY?
FUNERAL	8909 Tamar Drive					21045			Unit	ted	States
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS OECEDENT E FORCES? 1			13. WAS DEC	ENDENT OF HISPAN	IC ORIGIN? (S	pecify Yes	or No- 1	4. RACE	- American Indian, White, etc.
B	3X Widowed 4 Divorced	IF YES, GIVE WAR			1 TYES	2 NO Specify	:	, •		Specif	y:
	15. DECEDENT'S EQU	l			<u> </u>						White
	(Specify only highest grade	completed)	(G	Ve kind of wor Do NOT use	SUAL OCCUPATION The done during models The done of the desired to the desired t	DN ist of working	16b. KIN	D OF BUSI	NESS/INDU	STRY	
اي	Elementary/Secondary (0-12)	College (1-4 or 5 +)	1								
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		1	Iomema	ker			vn Ho			
						18. MOTHER'S NA			,		
BE	Frank A. Kearne	3				Kather			rgan		
2						and Number or Rural F					01045
	Jeanne Severin 20a, METHOD OF DISPOSITION	-				ck Lane (
	12 Burial 2 Cremetion 32 Ram	ovel from State	cemetery, crea	nd DATE OF natory or othe	DISPOSITION (No.	me of	DATE		ATION — CI		
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC	FNCEE	Park	Lawn i			6-21	Ham	pton,	, V1	rginia
	Λ				Harr	D ADDRESS OF FAC	ke Fur	neral	Home), I	nc.
	Shem Cal	lus			4112	Old Colu	mbia I	Pike	Ellic	ott	City 21043
	23. PART I. Enter the diseases, pro ahock, or heart fellure.	complications that co	nused the de	sth. Do not	enter the mo	da of dying, suci	aa cardiac	or respin	story arres	nt,	Approximate
	IMMEDIATE CAUSE (Finel										Interval Between Onset and Death
	disease or condition resulting in death)	LUN	GC	A N	CER						THREE
	Tooling in county		AS A CONSEC								CHINOM
Z		b									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OF	AS A CONSEC	UENCE OF):							
2	CAUSE (Disease or Injury	c									
#	that initiated events resulting in death) LAST	DUE TO (OF	AS A CONSEC	UENCE OF):							
E I	Tooling in death) CAST	d									
	PART II. Other eignificent condition	a contributing to de	ath but not re	sulting in	the underlying	cause given in	Part I. 24e	. WAS AN A	LITOPSY	24b.	WERE AUTOPSY FINDINGS
MEDICAL							- 1	PERFORM	ED7		AMAILABLE PRIOR TO COMPLETION OF CAUSE
							— ¹□	YES 2	Жио	1	OF DEATH?
Σ	DID TOBACCO USE CONTI	DIRLITE TO CALL	E OF DEAT	TH VEC	DNOF	LINICEDTAIN	187				1 TYES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL	GBOTE TO CAUS		_	(Check only one)	UNCERIAIN	الكرا			_	
<u> </u>	EXAMINER? 1 YES 2 NO	HOSPITAL:			THER:				NIA		
PHYSICIAN:	27. MANNER OF GEATH	28a, DATE OF INJ	URY	28b. TIME (e 5 ☐ Residence	28d. DESCRIE				
	1 Natural 5 Pending	(Month, Day,	(bar)	INJUR	Y WO	RK? — NO	200. DESCRIP		JOHT OCCO	MED	
B	2 Accident Investigation	28a. PLACE OF IN		ne ferm etre		-	284 I OCATIO	N (Ct-ot or	of Alexanders and	010	
		hulldlen ete	(Specify)	,,	or, rectory, offic		28t. LOCATION		o Number of	HUNNI HO	oute Number,
m II	3 Suicide 8 Could not be 4 Homicide detarmined	building, etc.									
	4 Homicide detarmined		-		-						
MPLETE	4 Homicide detarmined 29a. CERTIFIER (Check only)	CIAN: To the best of my									
COMPLETE	29a. CERTIFIER (Check only one) 29 MEDICAL EXAMINE	CIAN: To the best of my									and manner as stated.
3E COMPLETED	29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIER	CIAN: To the best of my				29c. LICENSE NUM	time, data and BER	place, and	due to the	ceuse(a)	and manner as stated, Month, Day, Year)
H	29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIER CA: 7 W	CIAN: To the best of my R: On the basis of exam	ination and/or li	rvestigation,	In my opinion, d	eath occured at the	time, data and BER	place, and	due to the	ceuse(a)	
	29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIER	CIAN: To the best of my R: On the basis of exam	DF DEATH (ITEM	vestigation,	In my opinion, d	29c. LICENSE NUM 29c. 4113	BER	place, and	due to the	ceuse(a)	
H	29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIER 29b. SIGNATURE AND ADDRESS OF PERSON WHI	CIAN: To the best of my R: On the basis of exam	OF DEATH UTEN	1 27) (Type, Pr	In my opinion, d	29c. LICENSE NUM	BER	place, and	due to the	ceuse(a)	



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		FOR STATE REGISTRAR	STATE OF MARYI	LAND / D CEF	EPARTM RTIFIC	ENT OF H	IEALTH AND I	MENTAL HYGIEN	E	
		1. DECEDENT'S NAME (First, Middle, Last) Ellis A. Kraus	s		4	Yau.		2. DATE OF DEATH MONTH D.	", 9 9 YEA	3. TIME OF DEATH
P		4. SOCIAL SECURITY NUMBER 222-12-1930 X	1 □XM 2 □ F 6	(In yrs. leat bi	rthday) #	UNDER 1 YEAR ITHE DAYS	IF UNDER 24 HRS. HOURS MIN.	Date of Birth (Month, Day, Mear) December	G	IRTHPLACE (State or Foreign
, 2, 3 should	стоя	98. FACILITY NAME (If not institution, give : PENINSULA REGION RESIDENCE OF DECEDENT		CENTER	9b.		SBURY	ATH	9c. COUNTY C	
nit. Pages 1,	DIRE	Md. Wico	mico	1		ntico			10d. INSIDE CITY LIMITS? 1 YES 2 X NO	
ian. transit permit,	FUNERAL	20421 Nantico					2184		τ	U.S.
215-0020 attending physician. ise as the burial-transit	BY	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	TK STNO	D		ecify Cuban, Maxican	IC ORIGIN? (Specify Yea n, Puerto Rican, etc.)	E	RACE — American Indian, Black, White, etc.
Spital or sed for s	PLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary [0-12)	College (1-4 or 5+)	(Give I life, Do	kind of work i NOT use ret		alth & sultant	166. KIND OF BUS		Health
YLA by the be def	E COMPL	17. FATHER'S NAME (First, Middle, Last) Ellis A. Kra	uss Sr.	1			18. MOTHER'S NAI	ME (First, Middle, Maiden Irene G		
MAR retained 5 should notified	TO B	19e. INFORMANT'S NAME (Type/Print) Ann P. Kraus					nd Number or Rural R	loute Number, City or Tow	n, State, Zip Code)
Page 6 may be all director, page iner must be		20a. METHOD OF DISPOSITION 1 GBuriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	200		DATEOFDI	SPOSITION (Na		NIO	CATION - City o	
SALT r death. re funer al.		21. SIGNATURE OF FUNERAL SERVICE LI			22. NAME AN	D ADDRESS OF FAC	SHITY	ick Fu .21814	neral Home	
of within 24 hours aft completely filled in by al, cremation, or remo	NO	23. PART I. Enter the diseases, or ahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition reauting in death) Sequentially list conditions,	Approximate on aach line. Approximate on aach line. Approximation on a cardiac or reapiratory arrest, interval 8 Onset and 30 onset a							
th certificate be ending physician I Hygiene prior to	CERTIFICATION	if any, leading to immediata cause. Entar UNDERLYING	c. DUE TO (OR AS /				,		0	
that the led by the lith and M	EDICAL	PART II. Other algnificant condition	na contributing to death b	but not reau	ilting in th	a undarlying	cause given in I	Part 1. 24a. WAS AN PERFOR 1 TYES 2	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
The law te has b ate Dept.	'SICIAN: M	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE O	F DEATH (C	heck only one)				1 YES 2 NO
PHYSICIAN this certific with the strike, or	BY PHYS	1 VES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	1 Inpatiant 2 PER/Out		DOA 4 D	28c. INJU		B Other (Specify) 28d. DESCRIBE HOW II	NURY OCCURED)
TTENDI TTOR: A after da	ETED E	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, atc. (Spe-	Y — At home, c/fy)	ferm, street	, factory, office		281. LOCATION (Street a City or Town, State)	nd Number or Rui	ral Route Number,
로 경상 =	COMPL	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	ICIAN: To the best of my know IR: On the bests of examination	viedge, death	occurred at	the time, data my opinion, de	and place, and due to	to the cause(s) end man	ner as stated.	se(a) and manner as stated.
TO THE HOSPI TO THE FUNEI De filed within	TO BE	296. SIGNATURE AND TITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON WH	2. Wennid	h. M.	D.		29c. LICENSE NUM	384	29d. DATE SIGN	995 (North, Day, Year)
		RODNEY IA	. WENRIC	H			ST. S	SALISBU	RY M	d. 21801
_ ~	- 1	JUN 1 2 199	32. BEGISTRAP'S SIGN	LOUR ROAD	1.11					



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

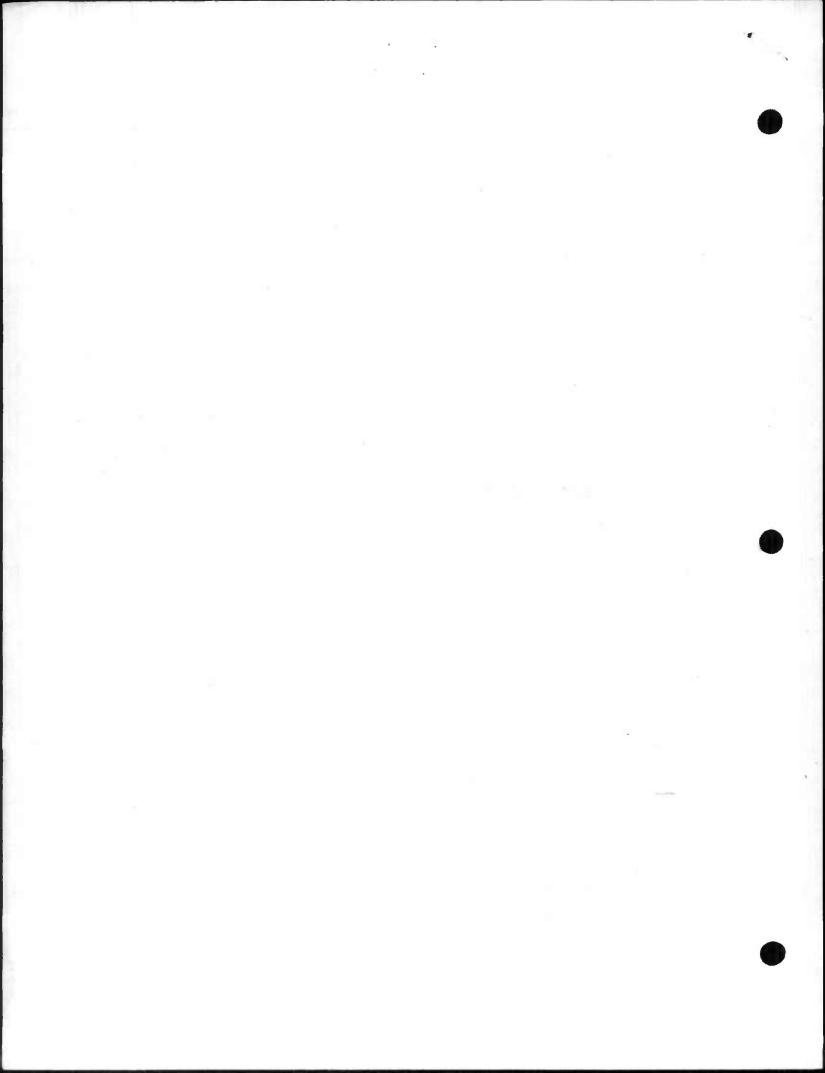
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

-04	5											
	ITEMS: 23 PART I			1					- W	5	20656	
	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND	DEPAR	TMENT	OF H	EALTH AND	MENTA	L HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last)							OF DEATH		T	3. TIME OF DEATH	
	ELIJAH	FREDERICK	7	KE	LLY	JR.	JU	NE 23	. 19	95	12:56	Fall.
		SEX 6. AGE (In yrs	lest birthday)	IF UNDER		IF UNDER 24 HRS.	7. DATE	OF BIRTH h, Day, Year)		_	PLACE (State or Fore	ign
	213 30 3700	X _{M 2} □ F 53	YRS.	MONTHS	DAYS	HOURS MIN.		6/41		Country	MD	
CC .	9a. FACILITY NAME (If not institution, give street					R LOCATION OF DI	EATH	-	9c. COUN	TY OF DE	ATN	
<u>0</u>	34802 OLD OCEA	N CITY ROAD)	P:	ITT	SVILLE			WIC	OMI	CO	
DIRECTOR	MD 106. COUNTY	icomico	10c. CIT	Pitt:							10d. INSIDE CITY LIMITS? 1 X YES 2 N	10
FUNERAL	104. STREET AND NUMBER 34802 Old Ocean	City RD			101.	21850					HAT COUNTRY?	
N.	11. MARITAL STATUS 12	2. WAS DECEDENT EVER IN U.S.	ARMED	13 V	MAS DECI	ENDENT OF HISPAI	MIC OBIGII	12 (Cnanth: Van		USA		
В	1 Never Married 2 Merried 3 Widowed 4 Divorced		NO	31	f yes, spe	ocify Cuban, Mexica NO Specif	n, Puerto		or No.		— American Indian , Whita, atc. ^{V:} White	,
COMPLETED	15. DECEDENT'S EDUCAT: (Specify only highest grade con	npleted)	Give kind of v	work done d			16b	. KIND OF BUS	SINESS/IND	USTRY		
MPL		College (1-4 or 5+)	Employ		t Of	ficer		State	of N	Mary	land	
	17. FATHER'S NAME (First, Middle, Last) Elijah Frederick	Kelly, Sr.				16. MOTHER'S NA			Surname)			
TO BE	19a. INFORMANT'S NAME (Type/Print)					nd Number or Rural i				COURT	13601	
۴	Fred Kelly		2180	0 He	eathe	er Acre	Dr.	Apt.3	A Wa	tert	own, NY	
	20s. METHOD OF DISPOSITION 1 Description 2 Comment of Specify 20c. Location - City of Town, State 20c								vn, State MD			
	21. SIGNATURE OF PROPERAL SERVICE LICENS	22. NAME AND AGORESS OF FACILITY Burbage Funeral 108 Williams St. Berlin, MD 218										
	23. PART I. Enter the diseasea/or comshock, or heart failure. List iMMEDIATE CAUSE (Final disease or condition resulting in death)	polications that caused the	F HEAD								Approximat interval Bet Onset and	ween
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CON										
PHYSICIAN: MEDICAL CE	PART II. Other significant conditions c	contributing to death but no	ot resulting i	n the uno	derlying	cause given in	Part I.	24a. WAS AN PERFOR	MED?		WERE AUTOPSY FINE AVAILABLE PRIOR TO COMPLETION OF CAI OF DEATN?) USE
ž	DID TOBACCO USE CONTRIB	SUTE TO CAUSE OF D	EATH YE	S D N	10 🗆	UNCERTAIN	N D				1 Des 2 - No	,
CIA	25. WAS CASE REFERRED TO MEDICAL		LACE OF DEAT	N (Check o	only one)							
, Si	1 XYES 2 NO	☐ Inpetient 2 ☐ ER/Outpetient	3 DOA	4 Nursi		5 X Residence	6 🗆 Othe	r (Specify)				
	27. MANNER OF DEATH 1 Netural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	FOUNT	E OF URY	28c. INJU	RK?		CRIBE NOW II		URED		
BY	2 Accident Investigation	FOUND: 6-23-95	11:4					CT WAS S	HOT			
	Suicide 8 Could not be 4 W/Homicide determined	28e. PLACE OF INJURY At building, etc. (Specify)					28f, LOC	3400			V CITY RD.	
E	29a. CERTIFIER		FOUND:					SVILLE,			D., MD.	
COMPLETED	(Check only 1 CERTIFYING PHYSICIAL	N: To the best of my knowledge										
8		On the basis of examination and	or investigation	n, In my op	pinion, de	eath occured at the	time, data	and place, an	d due to the	cause(a)	and manner as atal	led.
BE	296. SIGNATURE AND TITLE OF CERTIFIER	2				29c. LICENSE NUM					(Month, Day, Year)	0.5
٥ ا			7711 47 7			O.C.M	.E.		P J1	UNE	24, 19	95

OF DEATN (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201



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BOX 68760	practitad
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O. B.	ertificate
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DIVISION OF VITAL RECORDS, P.O. I	OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate he executed within a hours
20101	ATTENDING
5	DR
	OSPITAI

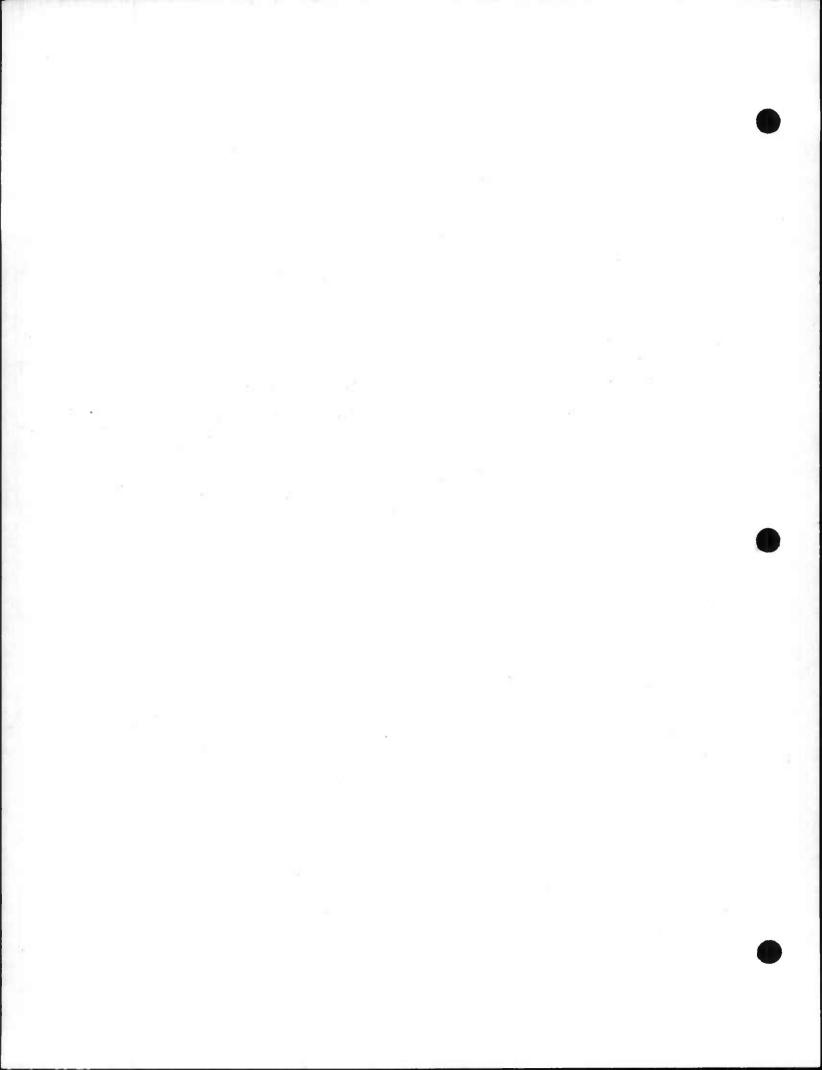
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH KNIGHT JAMES MONTH 9 YEAR 142 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTN 8. BIRTNPLACE (State or Foreign NOV . 2.7 80 1914 Country) XXM 2 | F Virgina 719-07-1879 permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR NORTHWEST HOSPITAL RANDLESTOWN BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE BALTIMORE YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 2942 W. North Avenue funeral director, page 5 should be detached for use as the burial-transit 21216 United States retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuban, Mexicen, Puerto Rican, stc.) 14. RACE — American Indian, Black, White, etc. **BALTIMORE, MARYLAND 21215-0020** 1 Never Merried 2 Merried 1 TYES 2 NO Specify: Black BY Specify: 3 Widowed 4 Divorced Navy COMPLETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Private 6th 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) John Frank Knight 76 Unknown Boone BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAJLING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16013 Chester Mill Terr. Silver Spring, 2 Woodrow Knight (Nephew) MID 2 Pe 20b. PLACE AND DATE of DISPOSITION, Name of Section Commetter, crematory or other place) California Commetter V 18

Knight Family Cemeter V 22. NAME AND ADDRESS OF FACILITY 20e. METNOD OF DISPOSITION

Duriel 2 Cremetion 3 Removal from State death. Page 6 may 20c. LOCATION - City or Town, State must 4 Donation 5 Other (Specify) Sulfork, VA examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Atlantis Long Funeral Service n by the f 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, medical Approximate filled in shock, or heert failure, List only one ceuse on each line. Interval Between cremation, or IMMEDIATE CAUSE (Finel Onset and Death NON SMALL CELL CARCINOMA OF LYNG,
DUE TO (OR AS A CONSEQUENCE OF): the disease or condition YEARY resulting in death) event. STAGE IV n and com to burial, traumatic CERTIFICATION Sequentially list conditions, if any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF): prior cause. Enter UNDERLYING CAUSE (Diseese or Injury other DUE TO (OR AS A CONSEQUENCE OF). that initiated events resulting in deeth) LAST 0 the atter PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE Signed by the shows any RONCHITIC 1 - YES 2 100 OF DEATH? 1 □ YES 2 🕅 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ₺ has by Dept. 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) certificate I 1 YES 2 NO HOSPITAL: OTHER: 1 | Inputient 2 | ER/Outputient 3 | DOA 4 Nursing Noma 5 Residence 8 Other (Specify) the marked, or 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE NOW INJURY OCCURED with 1 Natural 5 Pending 1 YES 2 NO BY After 2 Accident 28e. PLACE OF INJURY — At home, ferm, atreet, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 90 COMPLETED 8 Could not be TO THE HOSPITAL OR ATTENI
TO THE FUNERAL DIRECTOR;
be filed within 72 hours after
IMPORTANT; If item 28 is DIRECTOR: after 4 Nomicide 29s. CERTIFIER

(Check only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end manner se stated. 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) and manner as stated. 29c. LICENSE NUMBER
D37333 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) BE DJUNE 15,95 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MO, NHC, BALTO.MO 21133 32. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year) JUN 191995

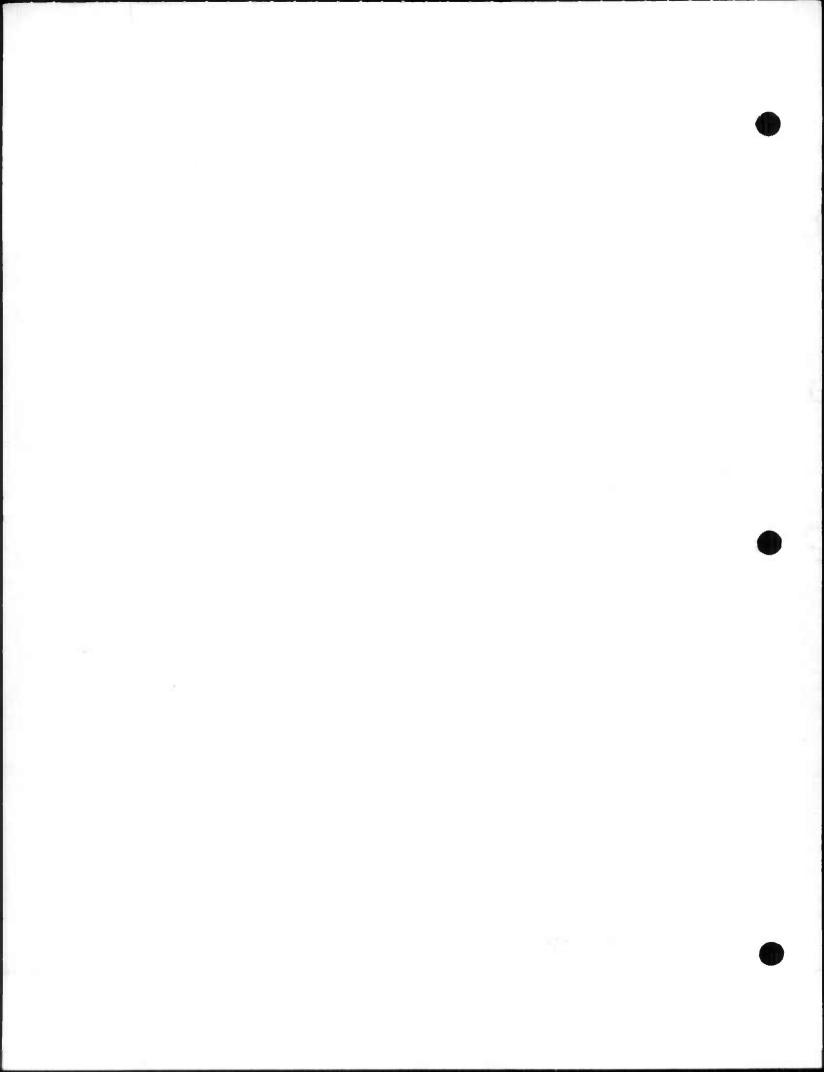


DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

						O=11111	TOATE	VI	DEA		HEG. NO			
		1. DECEDENT'S NAME (First, Mid	idle, Last)								2. DATE OF DEATH MONTH D	AY	VE	3. TIME OF DEATN
		Marv	r Ca	therine	LONG							1995	YEAR	4:50 PM M
		4. SOCIAL SECURITY NUMBER		5. SEX		s. lest birthday)	IF UNDER t	YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH		BIOTNO	LACE (State or Foreign
		214-46-5125		1 🗆 M 2 🕅 F	95	YRS.		DAYS	HOURS	MIN.	June 18,	1900	Country	hington DC
Pin					22	mo.								
3 should	~	9a. FACILITY NAME (If not institut					96. CITY, 1				ATH	9c. COUNT	Y OF DE	ATN
6,	DIRECTOR	200 East Sec		Street			Fr	rede	rick			Fre	deri	ck
₩.	2	RESIDENCE OF DECED												
900	2		Exad.	erick			Y, TOWN OR							10d. INSIDE CITY LIMITS?
***	_	Maryland	rreue	BLICK		1	reder	TCK						YES 2 NO
permit. Pages	AL.	100. STREET AND NUMBER		-			-	10f.	ZIP CODE	E _j		10g. CITIZI	EN OF WI	IAT COUNTRY?
ısı	8	200 East Se	cond	Street					2170	1		U.	S.A.	
cian. I-trar	FUNER	11. MARITAL STATUS		12. WAS DECEDEN	IT EVER IN U.S.	ARMED	12 14	NS DECI	ENDENT O	E MICDAN	IC ORIGIN? (Specify Yes	Wa	4.0105	A
320 Mysi ouria		1 Never Married 2 Mars	ried	FORCES? 1	YES 2	X NO	14	yes, spe	cify Cubs	n, Maxica	n, Puerto Rican, etc.)	W 140-	Black,	- American Indian, White, etc.
215-0020 attending physician, se as the burial-trar	B	3 Widowed 4 Divorced		IF YES, GIVE V	MAR OR DATES		1 (YES	2 X NO	Specify	pr ◆		Specify	White
15. as as	ED	15. DECEDER	NT'S EDITO	PATION	10-	DEGEDENTIA	HOUSE CO.			_		- 1		
or atte		(Specify only high	hest grade	completed)		(Give kind of a life. Do NOT us	work done du	iring mos	st of workin	g	16b. KIND OF BU	SINESS/INDU	STRY	
21 ital or	5	Elementary/Secondary (0-12)		College (1-4 or 5	+)	Arti					Pai	nting		
N hosp	\ ≥	12				112 03								
YLAND 21215-0020 by the hospital or aftending physician. be detached for use as the burial-transit at once.	COMPL	17. FATNER'S NAME (First, Middle,									ME (First, Middle, Maiden			
	BE	Patri	ck			LONG			M	arga	ret Ruth	HARV	ΕY	
MAR retained 5 should notified		19a. INFORMANT'S NAME (Type/F				19b. MAILING	ADDRESS ((Street ar	nd Number	or Aural F	loute Number, City or Tow	n, State, Zip C	ode)	
	2	Sister Marguerita	e The	rese Leary		200 E	ast S	eco	nd S	tree	t, Frederi	ck, M	d. 2	1701
MORE, age 6 may be director, page er must be		204 METHOD OF DISPOSITION			20h PLA	CE AND DATE	OF DISPOSIT	TION (No.	me of		DATE 20c, LO	CATION CI	h. a. Tau	- Carr
BALTIMORE or death, Page 6 may the funeral director, paya a		20a_METHOD OF DISPOSITION ABurial 2 Cremetion 3 4 Donation 5 Other (Soe	3 🗆 Remo	oval from State	cemetery	crematory or o	ther place)	+ Ch	~~~1	Ti moo	1			
Mirec direc	18	21. SIGNATURE OF FUNERAL SE		ENGER	_ VISI	LIALIOI						reder	ick,	MQ.
ALTI death. P funeral	1	21. SIGNATURE OF PUNEBAL SE	6	ENSEE			122. NA	AME AN	D ADDRES	d Ra	sford P.A.	Funo	ral	Homo
ALTIN death. Pag tuneral di f.		Michan	36	Ma	/ MO	0255								
B after of the by the imoval.		23. PART I. Enter the disease	500 OF C	omniicationa the	7		1.0	DO E	ast v	CHUL	ch St., Fr	ederi	CK,	
in the		ahock, or heart	failure. I	Liat only one cal	se on each	line.	rot emai ti	na moc	de or dy	ng, auci	i ea cardiac or reapi	ratory arre	Bť,	Approximata interval Batween
		IMMEDIATE CAUSE (Finel disease or condition		1-11					22		,	,		Onset and Daath
報節日本		resulting in death)		. HThe	rosc	lero7	tic (2010	110	VAS	ular di	5095	e	
760 ed withmoon completely al, crema	1			DUE TO	(OR AS A COR	NSEQUENCE OF	F):	-						
68760 executed with and complet o burial, cren	z													
4 B 0 F	CERTIFICATION	Sequentially list conditions if any, leading to immediate		DUE TO	(OR AS A COR	NSEQUENCE OF	F):							
BOX ficate be exphysician are prior to	8	cause. Entar UNDERLYING CAUSE (Disease or Injury	7 .											[
O. B. certificate ding physical property of their certificate property of their transfer of their transfer tran	正	that initiated events		DUE TO	(OR AS A CON	NSEQUENCE OF	F):							
V - ET E	듄	resulting in death) LAST	1112											
	빙													
ORDS, that the deared by the att the and Menta any injury,	7	PART il. Other aignificant c	ondition	contributing to	death but n	ot resulting	in the und	erlying	cause g	iven in l	Part I. 24s. WAS AN			VERE AUTOPSY FINDINGS
RECORD requires that the seen signed by the of Health and N shows any inj	MEDICAL	Dementi	a	Chron	16 11	ringi	ru 7	tra	fire	Fari	PERFOR			WAILABLE PRIOR TO COMPLETION OF CAUSE
signed Health Aws and		1/40.14	, /		- 4		7-1-	IMC	7 //	1 (4	1 TYES 2	₩O.		OF DEATH?
w requirements of the short	Σ	DID TOD LOCAL VICE	4/6	ydism									1	YES 2 NO
	PHYSICIAN:	DID DOBACCO USE	CONIK	RIBUTE TO CA					UNC	ERTAIN	1 🗆]			
A 9 2 2	ㅎ	25. WAS CASE REFERRED TO ME EXAMINER?	DICAL	HOSPITAL:	28. P	LACE OF DEAT								
VISION OF VIT, STENDING PHYSICIAN; The CITOR: After this certificate is after death with the State 128 is marked, or then	S	1 TYES 2 NO		1 Inpetiant 2	ER/Outpatien	H 3 DOA	OTHER:		5 A Ra	sidenca	6 Other (Specify)			
Sicial Sicial Control of or or	Ξ	27. MANNER OF DEATH		28a. DATE OF		28b. TIM	E OF 2	Bc. INJU	JRY AT		28d. DESCRIBE HOW I	NJURY OCCU	RED	
		1 Natural 5 Pend		(Month, D	чиу, төшг)	INJ	URY	1 Y	RK? ES 2	NO				
ONG ONG After death	ВУ	2 Cuista	itigation	28a, PLACE O	F INJURY A	t home, farm, s	treet, factor				28f. LOCATION (Street a	ad Number o	Dural Da	do Alizabas
ISIC TTEND TOR: /	ED	_ COUNT	d not be mined	building,	atc. (Specify)		A788C, 180107	y, office			City or Town, State)	ina reamber of	HUNIII MOI	ne Number,
	COMPLETE													
L DIRI	립	(Check only	NG PHYSIC	CIAN: To the best of	my knowledge	, death occurre	ed at the tim	e, deta	and place,	and dua	to the cause(a) and man	iner as stated		
HOSPITAL FUNERAL WITHIN 72 TANT: IF	8	one) 2 MEDICAL	EXAMINE	R: On the basia of a	xamination and	f/or investigatio	n, in my opi	inion, de	ath occur	ed at the	lime, data and place, an	d dua to the	cause(a) (and manner as stated.
A P W	- 1	296. SIGNATURE AND TITLE OF		- 1		4				NSE NUM				
	LLI II		1/	7/	lest.	for	7				DEN			Aonth, Day, Year)
물 물을 중	BE	/ // . 1	1/			The same		- 1	11 4'	5183		. 111	no ')	
TO THE HOSPIT TO THE FUNERA be filed within ?		(1/1)	1/1	fin	un				ט ט.	7105		O U.	ue z	0, 1995
TO THE DE FINE FINE FINE FINE FINE FINE FINE FIN	TO BI	30. NAME AND ADDRESS OF PER		/										
TO THE TO THE De filed IMPOR				frookteh	MD 30	00 Wes	t Nin	th S			Frederick.			
TO THE TO THE DE filed MADOR			es/Xi	frookteh	MD 30		t Nin	th S			Frederick,			



Pages 1, 2, 3 should

permit.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending p	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the to	be filed witthin 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH ewi. Howard 55 June 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country) (Month, Day, Year) 01/03/1891 HOURS MIN. 1 M 2 F 218-16-5018 YRS. 104 Virginia 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH % CONNTY OF PEATH SALISBURY PENINSULA REGIONAL MEDICAL CENTER DIRECTOR RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? Maryland Wicomico Salisbury 1 YES 2 | NO FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 520 Winder Street 21801 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2X300 IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yea or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indien, Bleck, White, etc. 1 Never Married 2 Married BY 3 Widowed 4 Divorced Specify: <u> African American</u> 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 0 self-employed Farming 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Herbert Lewis Sarah BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Miss Diane Smith P.O.Box 758, Fruitland, Maryland 21826 20e. METHOD OF DISPOSITION
1 ☑ Burlel 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 1 Suriel 2 Cremation 3 4 Donetion 5 Other (Specify) Union U.M. Church Cemetery 6/17 Delmar, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 1213 Jersey Road Jolley Memorial Chapels - Salisbury, MD 21801 23. PART i. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximata IMMEDIATE CAUSE (Final **Onset and Death** disease or condition 1.ROST ATE CAYCER. < IMORTE reaulting in death) DUE TO (OR AS A CONSEQUENCE OF) HYPOVE & STOWN, Kypertenoing Kenthisease 716 Yr. DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? 1 TYES 2 THO DF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 YES 2 NO 1 Inpetient 1 ER/Outpatient 399700A 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural ВУ M 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIONED (Month, Day, Year) BE

D32014

547 E RIVENSIDE DKIUE SALMBURY MD 2/801

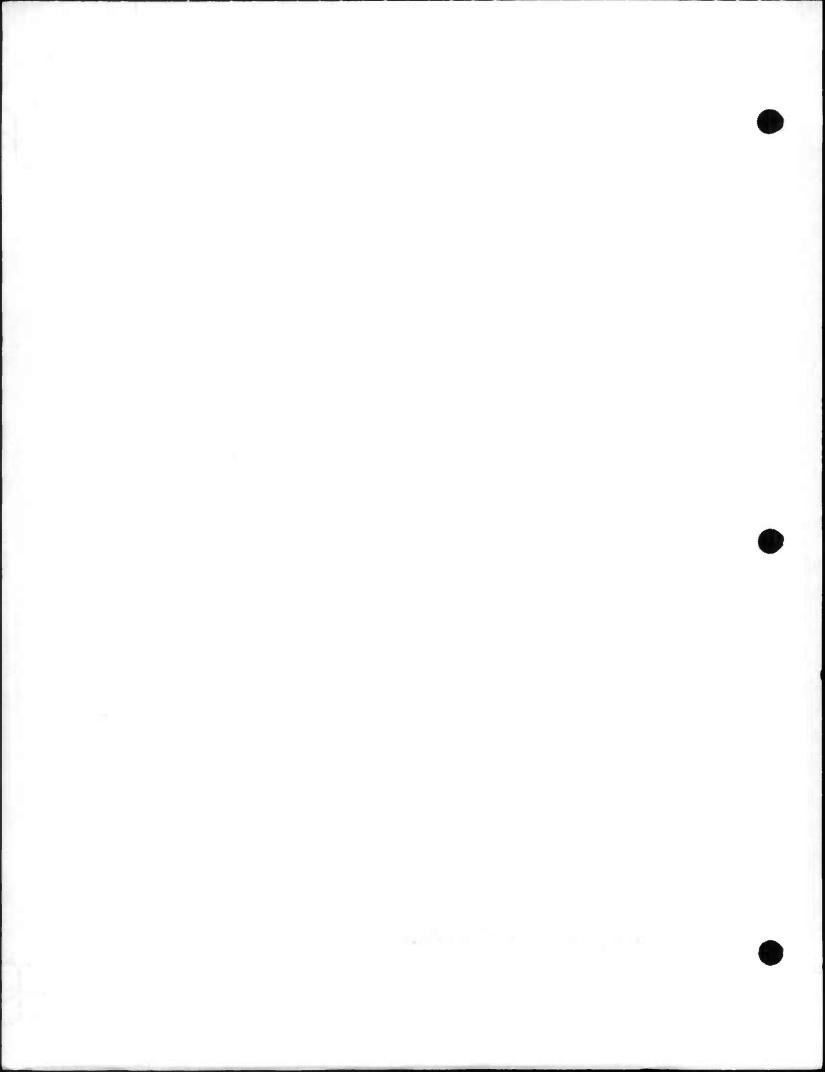
MAKENY MOOUDEA 31. DATE FILED (Month, Day, Year) JUN 16 1995

450 W 20

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Jalin d'aucher harlath

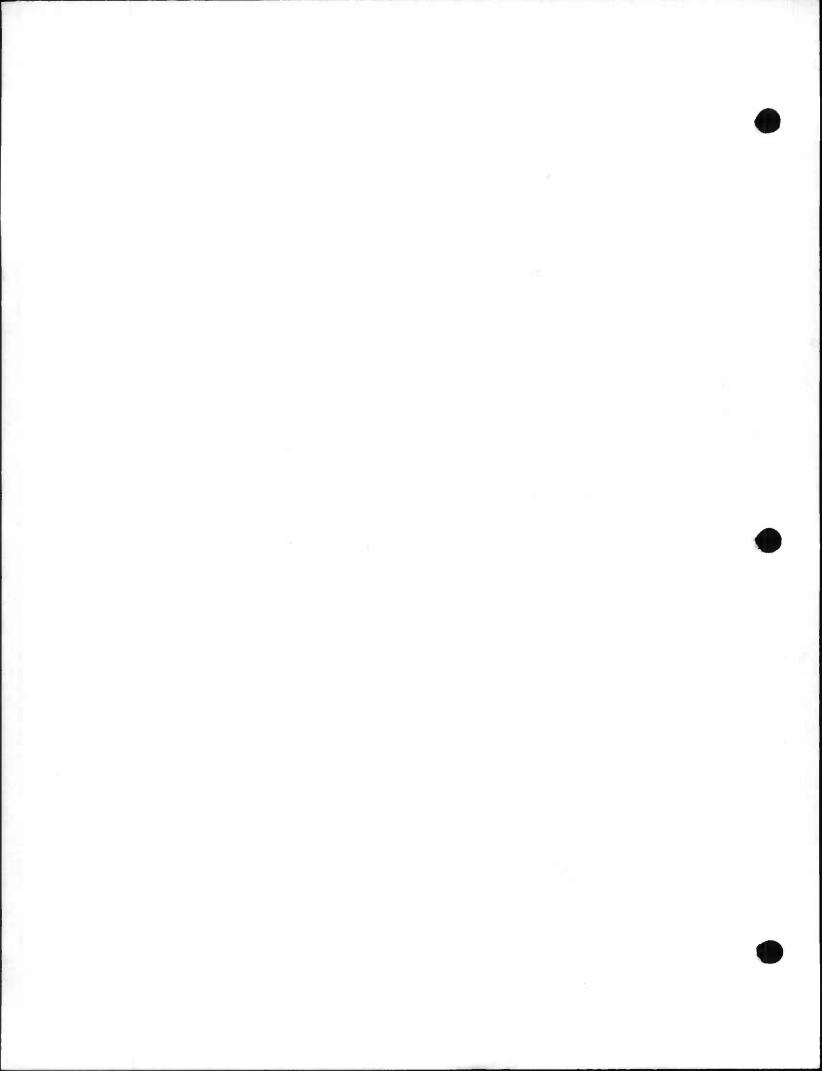
► 6/14/91



DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	HEGISTRAN				CATE	T DEA			REG. NO			
	1. DECEDENT'S NAME (First, Middle, Leat)	_						2. DATE OF	DEATH	AV.	VEAD	3. TIME OF DEATH
1 8	Elizabeth	Jane	Logan					June	26	5' 1	995	8:50 am
1 3	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (in yrs. les	t birthday)	IF UNDER I YEA		R 24 HRS.	7. DATE OF			6. BIRTH	IPLACE (State or Foreign
	216-24-2223	1 M 2 F	87	YRS.	MONTHS DAY	HOURS	MIN.	(Month, l	-	1908	Countr	y rvland
	9s. FACILITY NAME (If not institution, give	atreet and number)			9b. CITY, TOW	N DR LOCAT			, -,		NTY OF D	
<u>چ</u>	Union Hospital of	Cecil Co	untu	- 1							Ceci]	
DIRECTOR	RESIDENCE OF DECEDENT	OCCII OO	uncy		E1kt	on					oec1]	
1 11	10e. STATE 10b. CDUNT	ry		10c. CITY	, TOWN DR LO	CATION						10d. INSIDE CITY
ā	Maryland	Ceci1			Nor	th Ea	et					LIMITS?
A	10e. STREET AND NUMBER					101. ZIP COD				10g. CITI	IZEN DF W	VHAT COUNTRY?
FUNERAL	320 Bailiff Road					2	1901			IIr	ni tod	States
Z	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. AR	MED	13. WAS I			IIC DRIGIN?	Specify Ve			- American Indian,
	1 Never Married 2 Married	FDRCES? 1 [IF YES, GIVE WA		40	If yes,	specify Cubi	an, Mexica	n, Puerto Ric	en, stc.)	G NO-	Black	t, White, atc.
BY	3 🔀 Widowed 4 🗌 Divorced	11 123, 0172 184	n on bales		''''	ES 2 🙀 NO	Speciny	<i>(</i> -			Speck	™ White
COMPLETED	15. DECEDENT'S EDU		16a. DE	CEDENT'S	USUAL OCCUPA	ATION		16b. K	IND OF BUS	SINESS/INC	DUSTRY	
E	(Specify only highest gradi	completed) Cotlege (1-4 or 5+)	(G	ive kind of w Do NOT use	ork done during a retired.)	most of worki	ing					
교	8	000000 (1-4-0, 0-4)		memak	er			He	r ow	п Ноп	ne	
8	17. FATHER'S NAME (First, Middle, Lest)					16. MOT	HER'S NAI	ME (First, Mid				
	William M. Coll	ings						offman		Ourrentey		
8	19a. INFORMANT'S NAME (Type/Print)	21180	10	- MAILIND	ADDRESS (Stre					- 0	0.11	
2	John P. Logan											001
	20e. METHOD OF DISPOSITION				iney R		Lane,		_			
1 8	1 💢 Buriel 2 🗆 Cremation 3 🗆 Ren	novat from Stata	cemetery, cre	matory or oth	F DISPOSITION	(Name of	0	DATE	20c. LO	CATION —	City or To	Maryland
	4 Donation 6 Other (Specify)	CEMERK	INOTEN	East	Metho	dist (cem.	6/30	No	rth E	last,	Maryland
1	20100	7 /	7		Crot	ich Fu	inera	1 Hom	e			
	"Horas I	11116			127	South	Mai	n Str	eet.	Nort	h Eas	st MD 21901
	23. PART I. Enter the diseases, or	complications that	caused the de	eth. Do n								Approximate
	ahock, or heert failure. IMMEDIATE CAUSE (Final	List only one caus	e on each line).								Interval Between
	disease or condition	M		11		4	1					Onset and Death
		a. M	YOCAL O	he/	INF	RCH	102					
	disease or condition	DUE TO (OR AS A CONSEI	DUENCE DE	Info	rch	102					
NO	disease or condition resulting in death) Sequentially list conditions,	b CA	2			rch	102					
ATION	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	b CA	DR AS A CONSE			ned	102					
FICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	b DUE TO (C	OR AS A CONSEC	DUENCE DF):	neh	102					
RTIFICATION	disease or condition resulting in desth) Sequentially list conditions, if any, leading to immedista cause. Enter UNDERLYING	b DUE TO (C	2	DUENCE DF):	ned	102					
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	b DUE TO (C	OR AS A CONSEC	DUENCE DF):	ned	102					
AL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	b. DUE TO (C	OR AS A CONSE	DUENCE OF):				ia, WAS AN		24b.	Onset and Daath WERE AUTOPSY FINDINGS
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (C	OR AS A CONSE	DUENCE OF):			Part I. 2	PERFOR	MED?	24b.	Onset and Death
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MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (C	OR AS A CONSECUTION OF AS	DUENCE OF):): n the underly	ing cause	given in i	Part I. 24	PERFOR	MED?		Onset and Daath WERE AUTOPSY FINDINGS AMAILABLE PRIDE TO TO SEE THE TOWN TO S
MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (C	DR AS A CONSECUTION OF AS	DUENCE OF):): n the underly	ing cause	given in i	Part I. 24	PERFOR	MED?		WERE AUTOPSY FINDINGS AMAILABLE PRIGHT TO COMPLETION OF CAUSE OF DEATH?
MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	b. DUE TO (C. DUE TO (OR AS A CONSECUTION OF AS	DUENCE OF OBJECT): S NO H (Check only or	Ing cause	given in i	Part I. 2/	PERFOR	MED?		WERE AUTOPSY FINDINGS AMAILABLE PRIGHT TO COMPLETION OF CAUSE OF DEATH?
MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND	b. DUE TO (C. DUE TO (OR AS A CONSECUTION OF AS	DUENCE OF OBJECT): S NO H (Check only or OTHER: 4 Nursing H	UNC	given in i	Part I. 2/	PERFOR	MED?		WERE AUTOPSY FINDINGS AMAILABLE PRIGHT TO COMPLETION OF CAUSE OF DEATH?
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MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND 27. MANNER OF DEATH 1 Natural 5 Pending Investigation	DUE TO (C. DUE TO (C.	DR AS A CONSECUTION OF AS	DUENCE OF DUENCE OF THE YEAR OF DOAL INJURY	S NO H (Check only or OTHER: 4 Nursing H OF 28c. IRY M 1	UN(given in I	Part i. 24	PERFOR	MED?	CURED	WERE AUTOPSY FINDINGS AMAILABLE PRIDR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be	DUE TO (C. DUE TO (C.	DR AS A CONSECTION OF AS A CONSE	DUENCE OF DUENCE OF THE YEAR OF DOAL INJURY	S NO H (Check only or OTHER: 4 Nursing H OF 28c. IRY M 1	UN(given in I	Part I. 2. 1 Other (S 28d. DESCR	PERFOR	MED?	CURED	WERE AUTOPSY FINDINGS AMAILABLE PRIDR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
ED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND 27. MANNER OF DEATH 1 Natural S Pending Investigation 3 Suicide 6 Could not be determined	DUE TO (C. DUE TO (C.	DR AS A CONSECTION OF AS A CONSE	DUENCE OF DUENCE OF THE YEAR OF DOAL INJURY	S NO H (Check only or OTHER: 4 Nursing H OF 28c. IRY M 1	UN(given in I	Part I. 2. 1 Other (S 28d. DESCR	PERFOR YES 2 Specify) HIBE HOW II	MED?	CURED	WERE AUTOPSY FINDINGS AMAILABLE PRIDR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
ED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be detarmined 29a. CERTIFIER (Check only)	DUE TO (C. DUE TO (C.	DR AS A CONSECTION OF AS A CONSE	DUENCE OF DUENCE OF DESCRIPTION OF DOA 20b. TIME INJUITME, farm, at	S NO H (Check only or OTHER: 4 Nursing H G OF 1 28c. Interest, tectory, or	UNC Dome 5 Ri NJURY AT WORK? YES 2 [given in l	Part I. 24 1 6 Other (S 28d. DESCR	PERFOR YES 2 Specify) ON (Street at Storm, State)	NJURY OCC	CURED or Rural R	WERE AUTOPSY FINDINGS AMAILABLE PRIDR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
ED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be determined	DUE TO (C. DUE TO (C.	DR AS A CONSECTION OF AS A CONSE	DUENCE OF DUENCE OF DUENCE OF DEATH ODG DOA 28b. TIME INJU	S NO H (Check only or OTHER: 4 Nursing H OFF 28c. Intreet, tectory, or	UNC DOME 5 RI NJURY AT WORK? YES 2 Titles The and place and place	given in i	Part I. 2. 1 6 Other (S 28d. DESCR 28t. LOCATI City or :	PERFOR YES 2 Specify) HBE HOW II ON (Street a flown, State)	MED? ND NJURY OCC	CURED or Rural R	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO
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Pages 1, 2, 3 should

permit. completely filled in by the funeral director, page 5 should be detached for use as the burial-transit Page 6 may be retained by the hospital or attending physician. notified at pe must examiner hours after death. medical 6 the traumatic event, сгет inding physician and con Hygiene prior to burial, the attending physician a Mental Hygiene prior to the death certificate be other 1 6 been signed by th any requires that has be Dept. OR ATTENDING PHYSICIAN: The law 23 After this certificate I death with the State 6

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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DIRECTOR: A

TO THE HOSPITAL.
TO THE FUNERAL C
De filed within 72 h
IMPORTANT: If It HOSPITAL (

ITEMS: 23 PART I. 27, 28a-f. PER MEO FILM G-725 7/21/95 t.t STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH AM YEAR JONAS JUNE RICHARD LEWIS 10:32 P 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) Oct. 23, 1959 a. BIRTHPLACE (State or Foreign 213-68-0977 N M 2 □ F 35 DAYS HOURS YRS Maryland Se. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 15 SOUTH MA SOUTH MAIN STREET NORTH EAST CECIL COUNTY ton STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Cecil North East 1 X YES 2 NO FUNERAL 10s. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 15½ South Main Street 21901 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: t4. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) A.O. Smith Automotive Product Co. dary (0-12) College (1-4 or 5+) Twelve Years Welder Riverside, Maryland t7. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname Jonas Franklin Lewis BE Geneva Eubanks 19e, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Geneva E. Lewis 414 Ragan Road, Conowingo, Maryland 20e. METHOD OF DISPOSITION
t ☐ Burlel 2 ※ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State cametery, crematory or other place)
R.A. FERRIS & Company 4 Donation 5 Other (Specify) 6/23/95 West Chester, Pennsylvania 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Lee A. Patterson & Son Funeral Home hounain Perryville, Maryland 21903 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate ahock, or haert failure. List only one cause on sech line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition a. ACUTE AMITRIPTYLINE INTOXICATION resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, laading to immediata cause. Entar UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF)that initiated events reaulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a, WAS AN AUTOPSY YES 2 NO OF DEATH? 1 XYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ng Home 5 X Residence 6 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED t 🗌 Neturel FOUND ON 6/21/95 10:10 AM SUBJECT INGESTED DRUG ВУ 2 Accident 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 3) Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, Stete) 15-2 SOUTH MAIN STREET COMPLETED 8 Could not be 4 Homicide FOUND AT HOME 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(e) end menner ee stated. (Check only one) 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occured at the time, date end piece, end due to the cause(s) and menner ee stated. 296. SIGNATURE AND TITE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

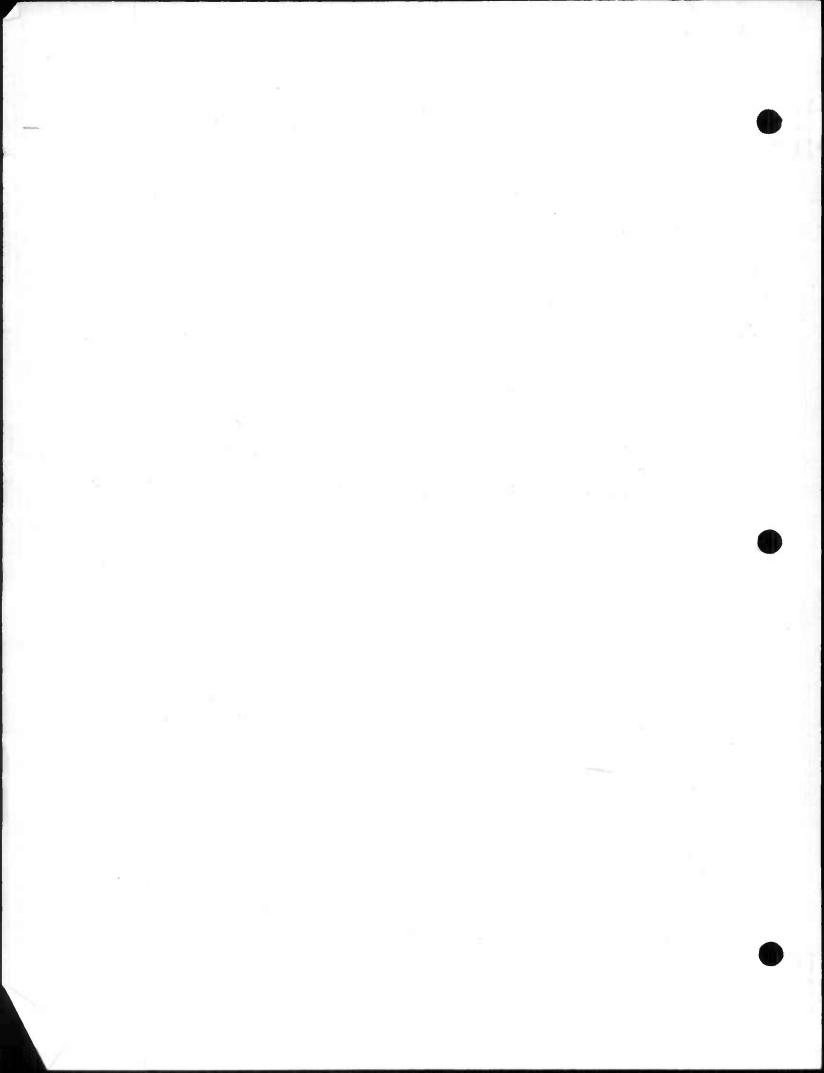
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32 REGISTRAR'S SIGNATURE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

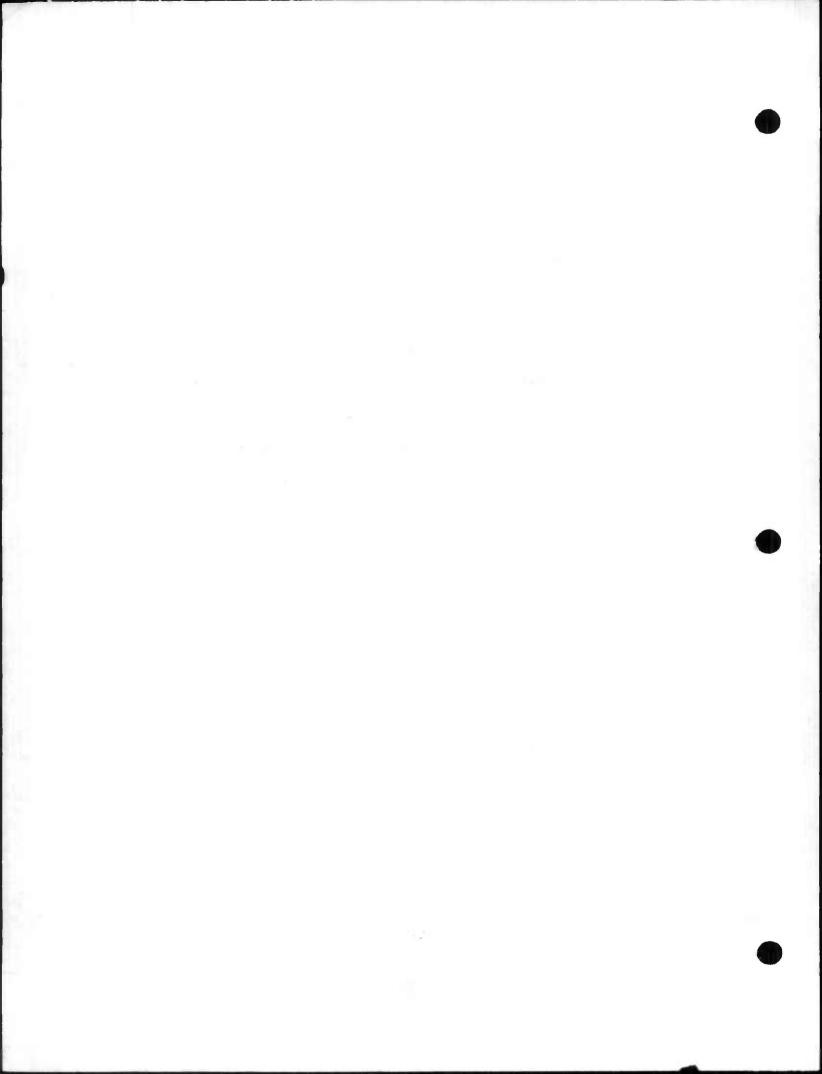
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JUNE 22,1995



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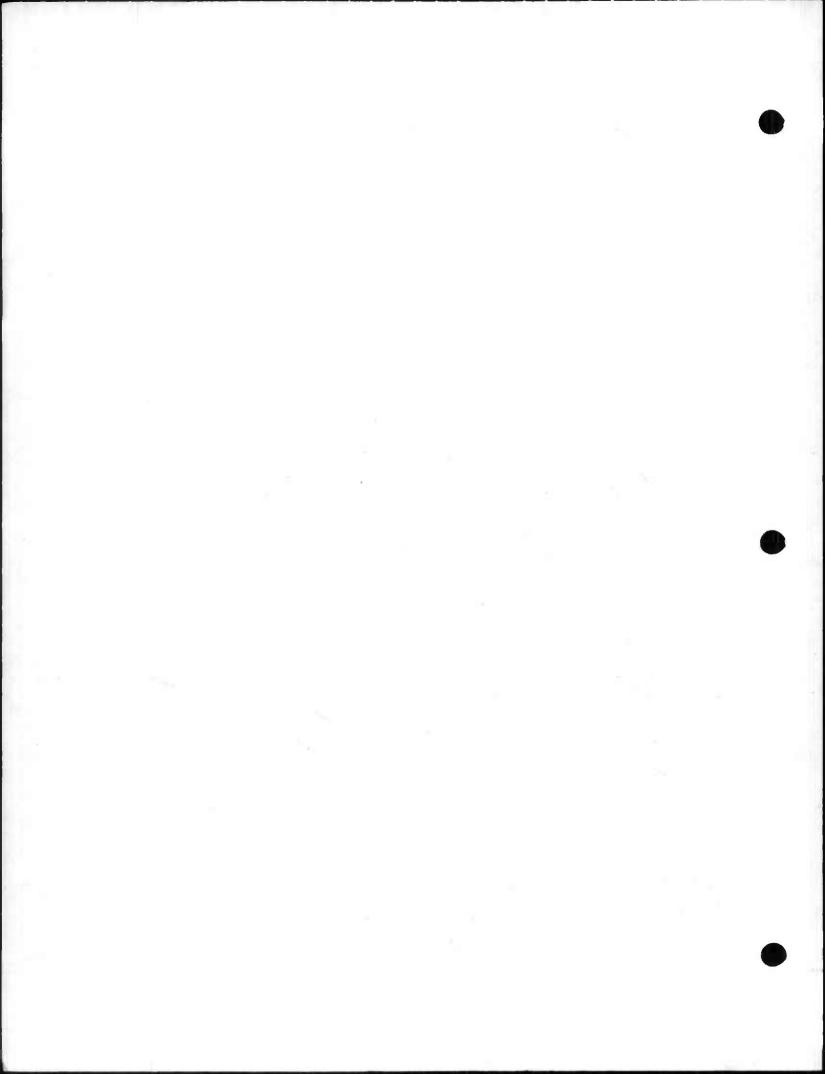
	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.				
			2. DATE OF OBATH JUNE 20 199	3. TIME OF OEATH 12:04P M	
once. COMPLETED BY FUNERAL DIRECTOR	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. last birthday) IF			BIRTHPLACE (State or Foreign
	577-60-8523 1XXM 2	□ F 48 YRS. MO	NTHE DAYS HOURS MIN.	(Month, Day, Year)	country) ashington,D.C.
	9a. FACILITY NAME (If not institution, give street and num		CITY, TOWN OR LOCATION OF DEA		
	National Institutes of Health Bethesda Montgomery				tgomery
	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS?				
		orges l	Jpper Marlboro		1XXYES 2 NO
	100. STREET AND NUMBER		101. ZIP CODE		
	10916 Layton Street 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED		20772	011.000 00000	
	III	37 1 TYES 2 X NO GIVE WAR OR DATES	If yes, specify Cuban, Maxican, 1 YES 2 X NO Specify:		RACE — American Indian, Black, White, atc.
	3人从Widowed 4 □ Divorced	GIVE TWIN ON DATES	TES 2 M NO Specify:		Specify: Black
	15. DECEDENT'S EOUCATION (Specify only highest grade completed)	16a. DECEOENT'S USU (Give kind of work	done during most of working	16b. KIND OF BUSINESS/INDUS	TRY
삗	Elementary/Secondary (0-12) College (1-12 th grade	4 or 5+) Ille. Do NOT use re	tired.)	Fadama I Day	
SMP G	17. FATHER'S NAME (First, Middle, Last)	Chauff		Federal Rese	erve Bank
E CC	I lhomas 1/:11:	Long	Janie	E (First, Middle, Malden Surname) Elizabeth	Holmes
ag ag	19a INFORMANT'S NAME (Smallprint)		DRESS (Street and Number or Rural Ro		
1 2	James M. Long (brother		leatherstone Dri		***
ts D	20a METHOD OF DISPOSITION 10 ABurlal 2 Cremation 3 Removal from St	20b. PLACE AND DATE OF O	ISPOSITION (Name of	DATE 20c. LOCATION - CIN	
2	Fort Lincoln Cemetery 6/26/95 Brentwood, Maryland				
examiner must be notified at once. TO BE COM	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Latney's Funeral Home				
	What Takey - Comou 3831 Georgia Avenue, N.W.; Wash. D. C. 20011				
The medical	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
	IMMEDIATE CAUSE (Fine) Onset and Death				
£	resulting in death) a. CCTC//G Dulmona Tele CCTC//S Dulmona Tele CCTC//				
injury, or other traumatic event,	DUE TO (DIT AS A CONSECUENCE OF):				
	Sequentially list conditions, Due to (or as a consequence of):				
CAT	ouse. Enter UNDERLYING				
	CAUSE (Disease Dr Injury that Initiated events DUE TO (OR AS A CONSEDUENCE OF):				
9 6	resulting in death) LAST				
AL C	PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY. 24b. WERE AUTOPSY FINDINGS				
	renal Sailvre			PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
shows any : MEDIC				OF DEATH?	
23 sh	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN				
CA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 46. PLACE OF OEATH (Check only one) TOTHER:				
28 is marked, or item 23 s TED BY PHYSICIAN:	1 YES 2 NO 1 Inpatie	nt 2 ER/Outpetient 3 DOA 4	Nursing Home 5 Residence 6	Other (Specify)	
		ATE OF INJURY 26b. TIME OF INJURY	WORK?	28d. DESCRIBE HOW INJURY OCCUR	RED
	2 Accident Investigation 3 Suicide 6 Could and by 26a. Pl	ACE OF INJURY At home, farm, atree	M 1 YES 2 NO	28f. LOCATION (Street and Number or	Second Streets Meanthur
	4 Homicide datarmined building, etc. (Specify)				TOTAL PROPERTY.
tem 2	29a. CERTIFIER (Check only (Check only 1) CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(s) and manner as stated.				
COMPL	(Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
MPORTANT: If item O BE COMPLE			29c, LICENSE NUMB		
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≥		CAUSE OF DEATH (ITEM 27) (Type, Print			8412
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	10 THE HOSPITAL OR ATTENDING PRESICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6	TO THE FLINEMAL DIRECTOR And make sertificate has been signed by the attending physician and completely filled in by the funeral director be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral.	IMPORTANT, If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner mu
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THE MITHING PRESIDENT The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
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	Lithal			NO	we.			June 20, 1945 810 A			8111 1 "
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (in yrs. last	hirthrima	IF UNDER 1 YEAR	IF UNDER 24				PLACE (State or Foreign	
		1 □ M 2 🔯 F	82	YRS.	MONTHS DAYS	_	MIN.	(Month, Day, Year)	_	Country	y)
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l l	9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DE										
DIRECTOR	11403 Bayard Drive Mitchellville, MD Prince George's										
<u>[</u>	RESIDENCE OF DECEDENT										
E	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS?		
	VA Caro	line		Ha	nover						1 TYES 2 NO
A	10e. STREET AND NUMBER					101. ZIP CODE			10g. CIT	IZEN OF W	HAT COUNTRY?
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FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. ARA	MED	13. WAS D	ECENDENT OF	HISPANIC (ORIGIN? (Specify Yes		14. RACE	- American Indian,
	1 Never Merried 2 Merried	IF YES, GIVE W	YES 2 X N	0		specify Cubsn, ES 2 X NO		ruerto Rican, etc.)		Black Specif	, White, etc.
ВУ	3 🔀 Widowed 4 🗌 Divorced				_ '''	Lo L'A	орвону.			Specif	Black
입	15. DECEDENT'S EDU (Specify only highest grade	CATION	16a. DEC	EDENT'S	USUAL OCCUPA	TION		16b. KIND OF BUS	SINESS/IN	DUSTRY	
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							lia P		Gurrielme)		
띪	Willie Mitchell 198. INFORMANT'S NAME (Type/Print)		1								
2			196.	1403	Bavaro	nend Number of	r Runal Route 2	e Number, City or Town	n, State, Zi	p Code)	
ı .	Ann Davidson				Bayard ellvill						
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ı	23. PART I Enter the diseases, of shock, or heart failure.	List only one ceu	t csused the dea se on each line.	ith. Do	not enter the n	nods of dyln	g, such e	s cardiec or respi	ratory sr	rest,	Approximate interval Between
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CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSEC	UENCE O	F):						
8	cause. Enter UNDERLYING	6									
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[]	EXAMINET?	HOSPITAL:			OTHER:						
ΥS	1 ØYES 2 □ NO	1 Inpatient 2					dence 8 🗆	Other (Specify)			
F	27. MANNER OF DEATH 1 Matural 5 Pending	28e. OATE OF (Month, Di	INJURY ay, Year)	28b. TIM		NJURY AT VORK?	28	d. DESCRIBE HOW I	NJURY OC	CURED	
B	2 Accident Investigation				M: 1	YES 2 []	NO				
ED	3 Suicide 6 Could not be	28e. PLACE O building,	F INJURY — At hore atc. (Specify)	ne, farm,	street, lactory, of	fice	28:	f. LOCATION (Street e City or Town, Stete)	nd Numbe	r or Rural A	oute Number,
	4 Homicide determined							.,,,			
7	29e. CERTIFIER (Check only 1 CERTIFYING PHYS	ICIAN: To the best of	my knowledge des	th occur	ad at the time de	to and place a	and then to t	ha annuals) and mi-			
COMPLET	(Check only one) 2 MEDICAL EXAMINE										and management at the
8				wasigatit	,y opinion	Commit december	- or transmitted	, unter end piace, en	u uus 10 11	re ceuse(e)	with manner es stated.
8E	296. SIGNATURE AND TITLE OF CHRINFIE	2				ANG. LICENS	SE NUMBER	н.	296. DAT	E SIGNED	(Month, Cley, Year)
10	() SUGUETO Y.X	tarke	CMD			421	230	0 5	1211	20 2	0,1995
F	TO MAME AND ADDRESS OF PERSON WH	O COMPLETED CAU	E OF DEATH (ITEM	27) (Type	pup .	-	0 0	0 1			11/
	HUGUSTOH BOOM	16 18 7	10.50	29/	You ken	m Ct	Car	21. m	21	7115	1
i	31. DATE FILED (Month, Day, Year)	32. REGISTRA	A'S SIGNATURE	//	700	11-11	14	1. 11-1	00	171	
	11111 00 1000	9 · Ac 1	P 1 11				. 4				



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

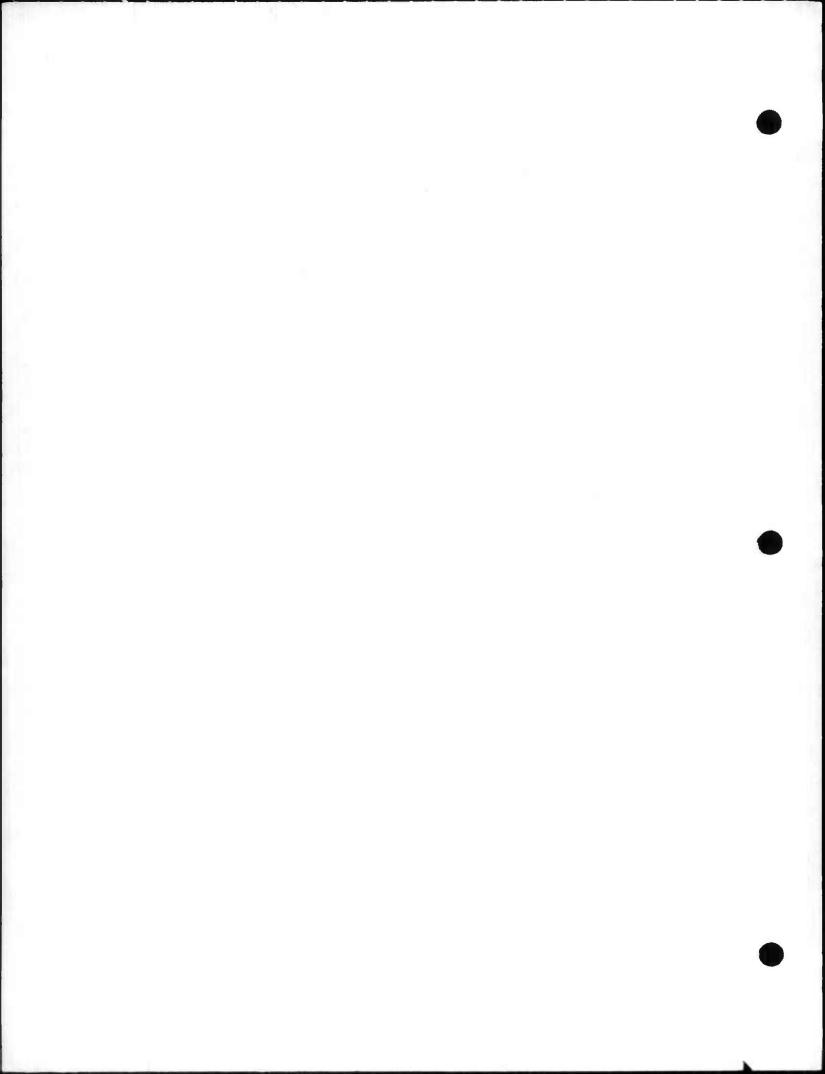
FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CER	TIFIC	ATE OF	DEATH		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF	DEATH			3. TIME OF DEATN
	Paul Franc	cis Lew:	is				June	13. 1		YEAR	7:05 A M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. A	GE (In yrs. last bir	thday) IF	JNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF (Month, D			S, BIRTH	
	227-07-9566	550		YRS. MON		HOURS MIN.	Septe	mber	20.	Country 17-1	PLACE (State of Foreign v) Marshall, rginia
	9a. FACILITY NAME (If not institution, give stre	eet and number)		9b.	CITY, TOWN	OR LOCATION OF D				NTY OF D	
FUNERAL DIRECTOR	Magnolia Gardens N	ne	Lanham				Prince George's				
m m	10a. STATE 10b. COUNTY		10	Oc. CITY, TO	WN OR LOCA	TION					10d. INSIDE CITY LIMITS?
<u>a</u>	Maryland Prince	e George's		Colle	ge Par	ck					1X YES 2 NO
AL	10e. STREET AND NUMBER				10	. ZIP CODE					VHAT COUNTRY?
5	4818 Erie Street					20740				ted Amer	States
5	11. MARITAL STATUS	12. WAS DECEDENT EVE FORCES? 1 7)		ENDENT OF HISPA			or No-	14. RACE	— American Indian, c, Whita, etc.
B≺	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OF				ecify Cuban, Maxica 2 X NO Specif		m, atc.)		Speci	
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION ompleted)	16a. DECED (Give A	ENT'S USU	AL OCCUPATI done during me red.)	ON st of working	16b. KI	ND OF BUS	INESS/INE		11200
Ľ	Elementary/Secondary (0-12)	College (1-4 or 5+)									
MF	5 17. FATNER'S NAME (First, Middle, Last)		Br	anch	Manage			Montk		Dai	ry
						18. MOTNER'S NA					
BE	Paul E. Lewis			A II II II I			E. G1.				
2	Frances L. Hillyan	r d				eet, Co					4.0
										207	
	20a, METHOD OF DISPOSITION 12 Burlal 2 Cramation 3 Remon 4 Donation 5 Other (Specify)	val from State	20b. PLACE AND cemetery, cremate	ory or other p	sposition (Ni 1 Ceme		6 PATE	20c. LO			
	21. SIGNATUR OF FUNERAL SERVICE LICE	MSEE #M0069		ISHAI	22. NAME A	ID ADDRESS OF FA	CILITY				rginia
	· Noward	A COLO	5 A		Saue: Falls	s/Capito Church,	1 Fun	eral	Serv	ice	
	23. PART I. Enter the diseases, pr co	mplications that cau	sed tha death	. Do not a				or reapli	ratory an	eat,	Approximate
	ahock, or heart failure. Li IMMEDIATE CAUSE (Final	lat only one cause or	n each ilna.								Interval Between Onset and Death
	disease or condition	Acute Ca	ardiac i	Failu	ro						1 Day
İ	resulting in death) a. Acute Cardiac Failure Due TO (OR AS A CONSEQUENCE OF):								1 Day		
z I	Myocardial Infarction 1 Day									1 Day	
CERTIFICATION	Sequentially list conditions, If any, laading to immediate DUE TO (OR AS A CONSEQUENCE OF):										
2	CAUSE (Disease or Injury	Diabetes	S Melli								20 Years
Ē	that initiated eventa reaulting in death) LAST	DOE TO (OR A	S A CONSEQUE	NCE OF):							
	d.										
	PART II. Other significant conditions	contributing to deati	h but not resu	lting in th	e undariyin	g ceuse given in	Part I. 24	a. WAS AN		24b.	WERE AUTOPSY FINDINGS
EDICAL	Chronic Azotaen	nia						PERFOR			AMAILABLE PRIOR TO COMPLETION OF CAUSE
ME									M.		OF DEATH?
ž I	DID TOBACCO USE CONTRI	BUTE TO CAUSE	OF DEATH	YES [J NOX	UNCERTAIL	NO				
<u>₹</u>	25. WAS CASE REFERRED TO MEDICAL			F DEATH (C	heck only one)						
PHYSICIAN:		HOSPITAL: 1 Inpatient 2 ER/O	Outpetlant 3 🗆 I		HER: Nursing Hon	e 5 🗆 Residence	6 Other (S	peclly)			
ᇎ	27, MANNER OF DEATN	28a. DATE OF INJUF (Month, Day, Yea	RY 28	b. TIME OF	28c. IN.		28d. DESCR		JURY OC	CURED	
BY	1)XX Natural 5 Pending 2 Accident Investigation	(Month, Day, rea	(1)	INJUNT		rES 2 NO					
	3 Suicide 8 Could not be	28a. PLACE OF INJL building, etc. (S	JRY — At home,	farm, street	, factory, offic		28f. LOCATIO	ON (Street a	nd Number	or Rural F	loute Number,
	4 Nomicide determined		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				City by i	own, State)			
COMPLET	29a. CERTIFIER 1XXCERTIFYING PNYSICI	AN: To the bast of my kn	owledge, death	occurred at	the time, data	and place, and dua	to the cause(e) and man	ner an stat	ed.	
one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mann) and manner as stated.			
Ŭ W	29b. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE NUI		1			(Month, Day, Year)
∞ ∥	M	An Q		70		D13668			D 6	_2	1-95
요	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF	DEATN (ITEM 27	(Type, Print)	D13000		1			, 13
	Azher Hussain, M.I					ege Parl	k, Mar	yland	207	40	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SI									
	JUN 21 1995 July	a d'avilente	dall								



DIVISION OF VITAL RECORDS, P.O. BOX 68760



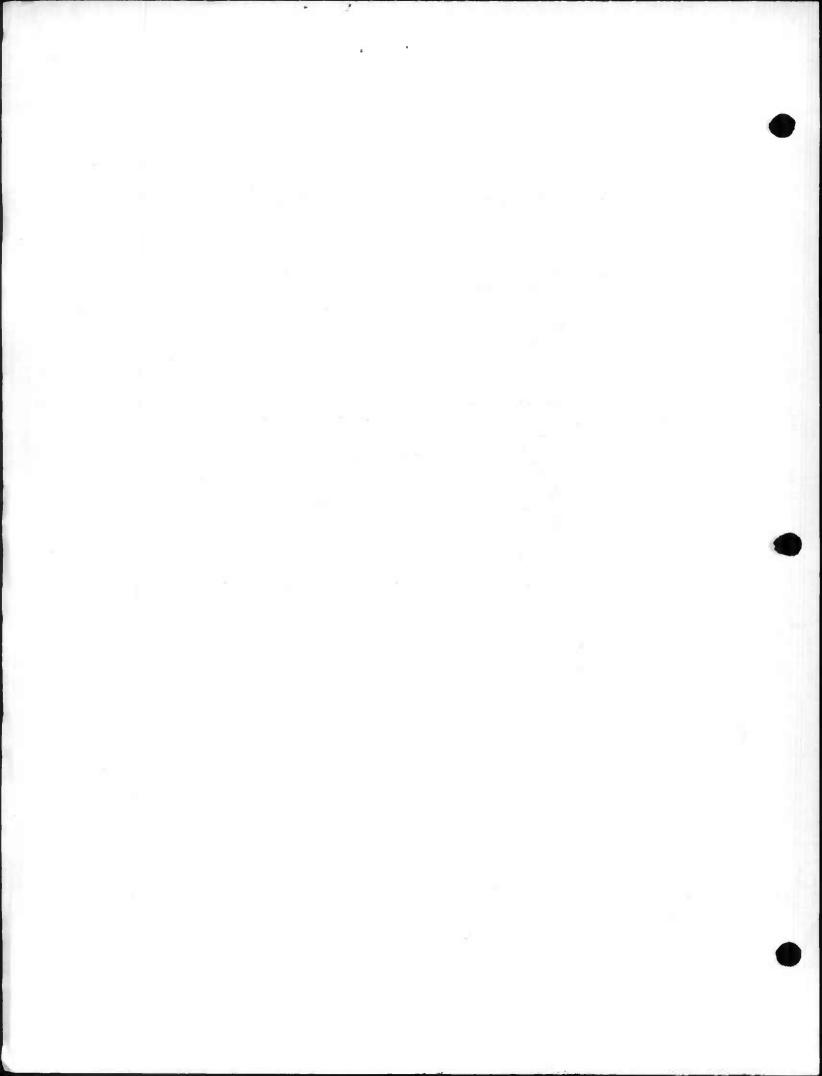
BALTIMORE, MARYLAND 21215-0020	with a nours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ent, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within nours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fibe within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15

		1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF HEALTH AN		
		1. DECEDENT'S NAME (First, Middle, Last)	Albert	Lee	J.	2. DATE OF DEATH	AV 1995 3. TIME OF DEATH
1/1	,	4. SOCIAL SECURITY NUMBER 421-82-7163	5. SEX 6. AGE ((In yrs. lest birthday) YRS.	IF UNDER 1 YEAR IF UNDER 24 H MONTHS DAYS HOURS MI	RS. 7. DATE OF BIRTH	8. BIRTHPLACE (State or Foreign Country) 959 ALABAMA
3 should	or.	9a. FACILITY NAME (If not Institution, give s			9b. CITY, TOWN OR LOCATION C	OF DEATH	9c. COUNTY OF DEATH
2,	FUNERAL DIRECTOR	1333 NALLEY TERR	ACE		Washington He	eights	Prince Georges
Pages		Maryland Prin	v ce Georges		town on Location ington Heights	2	10d. INSIDE CITY LIMITS?
permit.		10e. STREET AND NUMBER		wasii	101. ZIP CODE	<u> </u>	1 X YES 2 NO
		1333 Nalley Ter			20785		United states
the burial-transit	ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1XXYES IF YES, GIVE WAR OR D. 1982 - 1990	N U.S. ARMED 2 NO ATES	It yes, specify Cuban, Me	SPANIC ORIGIN7 (Specify Yearloan, Puerlo Rican, etc.) Specify:	14. RACE — American Indian, Black, Whita, atc. Specify: Black
for use as	LETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		(Give kind of w life. Do NOT use	,		USINESS/INDUSTRY
oetached once.	COMPL	17. FATHER'S NAME (First, Middle, Last)	5 +	MILITARY	Y OFFICER	U.S. A	
at or	ш	JAMES ALBERT LEE	1			S NAME (First, Middle, Maiden CE RIGGS	Sumame)
o should be detached notified at once.	TO B	19a. INFORMANT'S NAME (Type/Print)			ADDRESS (Street and Number or R		
t be m		LARRY D. GRANT	20t		NALLEY TERRACE		N HTS MD 20785 DCATION — City or Town, Stata
rector, p		1 Name 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	A	netery, cremetory or oth RLINGTON	NATIONAL CEM.	6/23 ARI	LINGTON , VIRGINIA
or in by the funeral director, page or removal. medical examiner must be		21. SIGNATURE OF FUNERAL SETVICE U	Pope la	M859	5538 MARLB	S. POPE FUNE	ORESTVILLE MD 20747
cremation, or removent, the medica		23. PART I. Enter the disease, or shock, or heart failure. iMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cause on e	ech line.	or enter the mode of dying, and deficies in	such as cerdiec or resp	Piratory srrest, Approximate intervsi Batween
the attentioning physician and completely med in by the Mental Hygiene prior to burial, cremation, or removal ijury, or other traumatic event, the medical	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initisted events resulting in deeth) LAST	b. DUE TO (OR AS A	CONSEQUENCE OF):	V	
y une attended Mental		PART ii. Other significent condition	ns contributing to death b	ut not resulting is	the underlying cause giver	n in Pert I. 24s. WAS AN	AUTOPSY 24b, WERE AUTOPSY FINDINGS
of Health and shows any li	I: MEDICAL	DID TOBACCO USE CONT				PERFOR	RMEO? AVAILABLE PRIOR TO
he State Dept or Item 23	CIA	25. WAS CASE REFEMBEO TO MEDICAL EXAMINED!		26. PLACE OF DEAT			
the St	PHYSICIAN:	1_P YES 2 NO 27. MANNER OF BEATH	1 ☐ Inpetient 2 ☐ ER/Outp 28e. DATE OF INJURY	etlent 3 DOA	4 Nursing Home 5 Thesider	nce 6 Other (Specify)	IN HIPV OCCUPED
after death with 28 is marked,	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU	M 1 YES 2 NO		NJURY OCCURED
s after de	8	3 Suicida 8 Could not be 4 Homicide datermined	28a. PLACE OF INJURY building, atc. (Spec	— At home, tarm, st	reet, factory, office	281. LOCATION (Street City or Town, State)	and Number or Rural Route Number,
20 =	COMPLET				d at the time, date and place, and		nner as stated. nd dus to the cause(s) and manner as stated.
be filed within 7	TO BE C	30. NAME AND STORESS OF PERSON WHI	Hedrijux	МН (ITEM 27) (Туре,		NUMBER D21230 \	298. DATE SIGNEO (Month, Day, Year) NUNL / 7, / 9 95
			11	. 5009		Camp Spri	ings, MD 20748
		JUN 21 1995 Ju	by Dhurles Rand				

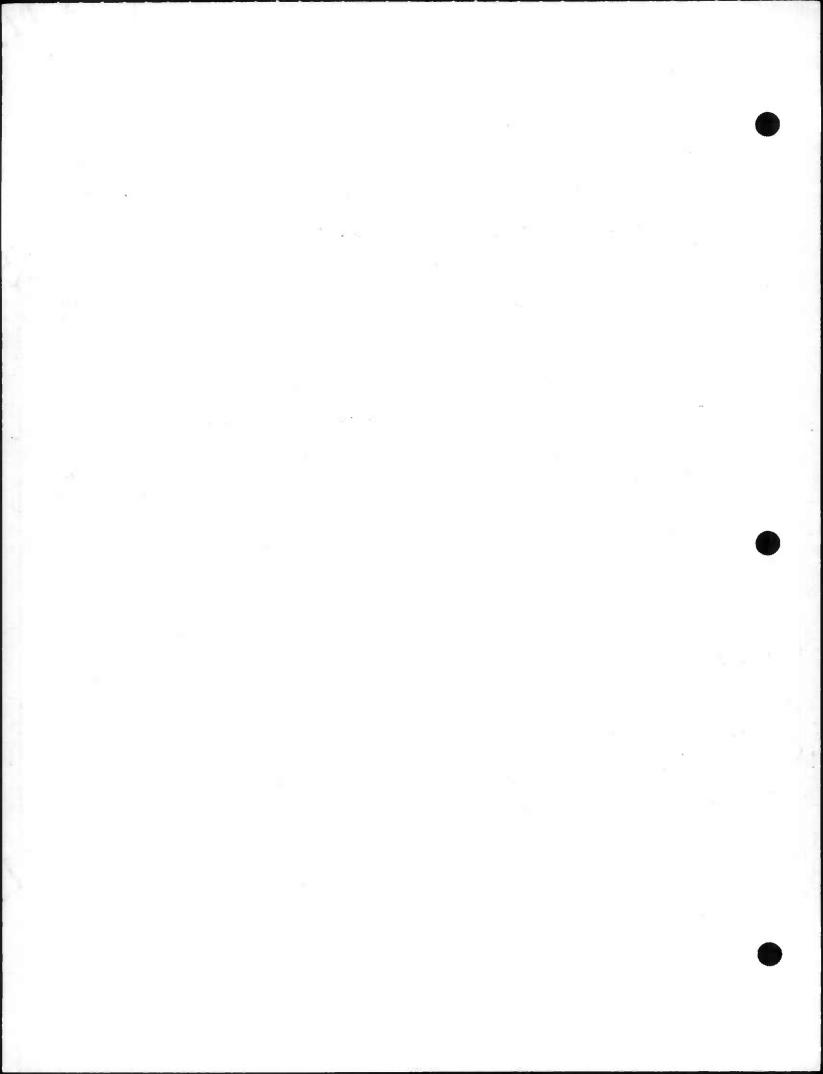
BALTIMORE, MARYLAND	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Cours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached he fined within 72 hours after death with the State Deat, of Health and Mental Horiene prior to burial, cremation, or removal.	IMPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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DIVISION OF VITAL RECORDS, P.O. BOX 13146,	CIAN	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within Z hours after death with the State Debt, of Health and Mental Hydiene prior to burial, cremation, or removal.	6
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	1 - STATE REGISTRAR	STATE OF MARY			F HEALTH		MENTAL HYGI REG.			
	1. DECEDENT'S NAME (First, Middle, Lest) Julia Lawre	nce					2. DATE OF DEATH	Н	EAR 3.	TIME OF DEATH 6:15 A M
	4. SOCIAL SECURITY NUMBER		E (In yrs. last birthday)	IF UNDER 1 YE	AR IF UNDER	24 HRS.	7. DATE OF BIRTH	. a.	BIRTHPL	ACE (State or Foreign
	213-20-8520	85 YRS.	9-27-1909					Virginia		
	Se. FACILITY NAME (If not institution, give		9b. CITY, TO	WN OR LOCATION	ON OF DE	ATH	9c. COUNTY			
6	Carroll Manor N	ursing Home		I	Hyatts	7 111 e	2	Pr	ince	Georges
EC.	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			Y, TOWN OR L	OCATION				16	Od. INSIDE CITY
DIRECTOR	D.C.			Wash:	ington				1	LIMITS? YES 2 NO
	10e. STREET AND NUMBER				10f. ZIP CODI	E		10g. CITIZE	N OF WHI	AT COUNTRY?
FUNERAL	2824 12th Stree	et, N.E. Apt	. # 103		2	20017	7	Uni	ted	States
BY FU	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2 NO	If ye	DECENDENT Cos, specify Cuba	n, Maxicar	IIC ORIGIN? (Specifi n, Puerto Ricen, atc. :	y Yea or No 14	Black, V Specify:	- American Indien, White, etc. Black
ED.	15. DECEDENT'S EDI. (Specify only highest grade	JCATION .	16a. DECEDENT'S	USUAL OCCU	PATION og most of workin		16b. KIND OF	BUSINESS/INDUS	TRY	2200
W	Elementery/Secondary (0-12)	College (1-4 or 5+)	Me. Do NOT u	work done durin se retired.)	ng most of working	ng	Ma	1.001	,	
COMPL	12		1	Nurse			med	11041		
BE CO	17. FATHER'S NAME (First, Middle, Lest) Sandy Johnson					Car	ME (First, Middle, Me Tie Masc	on		
2	19a. INFORMANT'S NAME (Type/Print) Lillian F. John	nson	19b. MAILING 282	ADDRESS (St 24 12tl	Stree	or Rural R	Noute Number, City or N.E. Wash	ington,	D.C	20017
	20a METHOD OF DISPOSITION 1 Description 2 Description 3 Ren 4 Donation 5 Dispersion 3	novel from Statu	other place) Fo	ort Lir		netory or	200	Brentwo		
	21. SIGNATIONE OF PUNCHAL SERVICE A	B. Ho	f-		AE AND ADDRE		Jor	nnson &		
	23. PART I. Enter the diseases, or	complications that caus	sed the death. Do	not enter the	mode of dy	ing, such	St. N.V	espiretory arres	t,	Approximate
	IMMEDIATE CAUSE (Fine)	List only one ceuse on	eech iina.							Interval Between Onset and Death
	disease or condition resulting in death)	ive Cereb			24hrs.					
NO	Sequentially list conditions, Hypertensive Atherosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF):									Years
CAT	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	C.								
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS	S A CONSEQUENCE O	F):			-			
_	PART II. Other algnificant condition	ne contributing to death	but not resulting	In the under	dylna causa i	niven in	Dart I 24 MM	S AN AUTOPSY	24b W	ERE AUTOPSY FINDINGS
CAL			- wat not rooming	iii dio dileoi	Tynig codes	9	PER	REFORMED?	A	MAILABLE PRIOR TO OMPLETION OF CAUSE
ED	-31.13.						_ ' '	S 2 NO		F DEATH?
2	- 表演的								ļ .	
NA I	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				86. PLACE OF D	EATH (Che	eck only one)			
S	1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/O	utpatient 3 🗆 DOA	OTHER:	Home 5 🗆 Re	asidence	S Other (Specify)			
BY PHYSICIAN: MED	27. MANNER OF DEATH 1 Natural 8 Pending 2 Accident Investigation	28a. DATE OF INJUR (Month, Day, Year	Y 28b. TIN	JURY	c. INJURY AT WORK?	□ NO	28d. DESCRIBE H	OW INJURY OCCU	RED	
2 Accelerate 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street, factory) City or Town, Sta							reet end Number or State)	Rural Rou	ite Number,	
COMPLE	one)	SICIAN: To the best of my kind ER: On the basis of examinar								and menner as stated.
O BE C	2914 SIGNATURE AND TITLE OF CENTIFIE NUTTURE AND TITLE OF CENTIFIE NUTURE	reiderthe	5		Da	63	3/	> 61	IGNED (M	fonth, Day, Year)
-	30, NAME AND ADDRESS OF PERSON W.	WESDER NOS	DEATH (ITEM 27) (Type	AMAS	LEDNA) Wh	SH.DCZ	0016		
	JUN 19 1995	LA CONTROLISTO AND	GATURE .							



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OR	OUR	
IOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the hours after death. Page 6 may be retained by the	UNERAL DIRECTOR: After this certificate has been signed by the attenting physician and completely filled in by the furnish director, page 5 should be delifting 72 hours after death with the State Deor, of Health and Mental Hydiene prior to burial cremation, or remains	100 to 10
PIL	ER.	F
8	3 E	3

		REGISTRAR		CERTIF	ICATE OF	DEATH	R	EG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF I	DEATH	3. TIME OF DEATH	
		HARRY LEE	LaCOSTE				June	10, 19	95 7:00 A M	
	l	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF E		8. BIRTHPLACE (State or Foreign	
		578-12-7998	1 🔯 M 2 🗆 F	74 YRS.	MONTHS DAYS	HOURS MIN.	(Month, De	y, Year)	Maryland	
pjno	- 1	9e. FACILITY NAME (If not institution, give a	street and number)	7 -	9h CITY TOWN	OR LOCATION OF E			TY OF DEATH	
3 should	œ	Magnolia Gardens		3.0		ON LOCATION OF E	EAIN			
. 2	DIRECTOR	RESIDENCE OF DECEDENT	Nutstile noil	ie	Lanham			Prin	ice George's	
Sec	Ä	10a. STATE 10b. COUNT	Y	10c. CI1	TY, TOWN OR LOCA	TION			10d. INSIDE CITY	
£:	<u></u>	Maryland Princ	e George's	Co1	lege Par	rk			LIMITS?	
ermi	4	10e. STREET AND NUMBER				H. ZIP CODE		10g, CITIZ	ZEN OF WHAT COUNTRY?	
Usit D	ER	6100 Westchester	Park Drive	Apt. #420		20740		U.S.		
5-0020 ending physician. as the burial-transit permit. Pages 1, 2,	FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER I	IN U.S. ARMED		CENDENT OF HISPA	NIC ORIGIN? (Si		14. RACE — American Indian,	
215-0020 attending physic		1 Never Married 2 Merried	FORCES? 1 X YES		If yes, s	pecify Cuben, Mexic S 2 NO Speci	an, Puerto Rican	, etc.)	Black, White, atc.	
ding ding	ВУ	3 Widowed 4 Divorced	WW II		'''	S 2 IQ NO Speci	ny.		Specify: White	
215 atten se as	0	15. DECEDENT'S EDU (Specify only highest grade	CATION	16e. DECEDENT'S	USUAL OCCUPAT	ION	16b. KIN	D OF BUSINESS/INDL	USTRY	
2121 al or atte	4	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	work done during m ise retired.)	lost of working				
AND he hospit detached	MP	11		Tool Ma	.ker		Boo	k Bindery		
AN the hox detach	COMPLET	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S N	AME (First, Middle	s, Meiden Surneme)		
M P	ш	Josh Grace LaCos	te			Amelia	Gladys	Dinsmore		
; MARYLAND 21215-0020 be retained by the hospital or attending physician, ge 5 should be detached for use as the burial-tran e notified at once.	8	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	G ADDRESS (Street	end Number or Rural	Route Number, C	ity or Town, State, Zip	Code)	
	2	Patricia A. Gate	S					d, Maryla		
IMORE, Page 6 may be director, page		20e. METHOD OF DISPOSITION	201	b. PLACE AND DATE	OF DISPOSITION /A	lame of	DATE	20c LOCATION C	Ity or Town State	
6 may ctor, p		1 № Buriel 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	D State	Veteran'	s Cemete	ry 6/14/	95 Chelte	nham. MD	
BALTIMOR in death. Page 6 maj the funeral director, p ad.	- 1	21. SIGNATURE OF FUNERAL SERVICE LI	ensee		22. NAME A	ND ADDRESS OF F	ACILITY	75 0.10100	Home, P.A.	
ALTIN death. Pag huneral di examiner		▶)	(1)							
B after by the mount	\vdash	23 PART I Enter the distance of		datilatin n	4/39	Baltimor	e Aveni	ue, Hyatt	sville, MD	
		23. PART I. Enter the diseases, or shock, Dr heart fallure.	List only one ceuse on a	ech line.	not enter the me	ode of dying, au	ch aa cardlac	or reepiratory arre	Approximate interval Between	
y filled	ł	IMMEDIATE CAUSE (Final disease or condition	100	1000		0.0	00.00		Onaet and Death	
with mpletely fille cremation,		resulting in death)	a. V///	1907001	5 (1)	Duche	MH_			
N 8 8 - 10			DUE TO (OR AS /	A CONSEQUENCE O	F):					
66 and and bur	S I	Sequentially list conditions,	b	TASI	RAIC	1115234	95			
De pe	F	If any, leading to immediate cause. Enter UNDERLYING								
m to to	5	CAUSE (Disease or injury 5 c.								
certificat ding phy tygiene p	Ē	that initiated eventa resulting in death) LAST	DOE TO (ON AS)	A CONSCOUENCE O	·).					
eath cath mal Hy	CERTIFICATION		d							
CORDS, P.O. B(res that the death certificate rigned by the attending physically and Mental Hygiene pr	- 11	PART II. Other algnificent condition	e contributing to death t	but not resulting	in the underlyin	ig ceuse given in	Pert I. 24e.	WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS	
COR es that igned by Baith an	EDICAL						1,5	PERFORMED?	AVAILABLE PRIOR TO COMPLETION DF CAUSE	
RECO requires th sen signed of Health							''	123 2 K	OF DEATH?	
St. of	N.	DID TOBACCO USE CONT	RIBUTE TO CAUSE C	OF DEATH Y	ES II NO I	LINCERTAL	NΠ		1 YES 2 NO	
4 0 E 0 -	SICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEA						
F VITA SICIAN: The certificate It the State It. or Item	Sic	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Out	patient 3 DOA	OTHER:	ne 5 🗆 Residence	4 D OH (0-			
PHYSICIAN: this certifical with the St inked, or It	PHY	27. MANNER OF DEATH	26a. DATE OF INJURY	26b, TIN	E OF 26c, IN	JURY AT		E HOW INJURY OCCU	URED	
NG PHYS fler this eath with	- 68	Natural 5 Pending	(Month, Day, Year)	IN.	JURY W	ORK? YES 2 □ NO		E TON MOON GOOD	, men	
ONG DING After death	À	2 Accident Investigation 3 Suicide & Could not be	26e. PLACE OF INJURY	/ — At home, farm.			281 LOCATION	N (Street and Number of	ne Ocean Charles Manuface	
DIVISION DIRECTOR: After hours after death item 28 is man		4 Homicide 6 Could not be	building, atc. (Spec	cf(y)	ander, rectory, orm		City or Tox	vn, Stete)	y nurai noute number,	
DIV DIREC DIREC Hours	<u>u</u>	29e. CERTIFIER								
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	MPL	(Check only CERTIFYING PHYSI	CIAN: To the best of my know							
HOSPITAL FUNERAL WITHIN 72 I	8	2 MEDICAL EXAMINE	R: On the beele of axaminatio	on end/or investigation	on, in my opinion,	death occured at the	time, date end	place, end due to the	cause(s) end menner ae stated.	
THE HOSPI THE FUNER filed within	BE	29b. SIGNATURE AND TITLE OF CERTIFIES	· · dom	מ		29c, LICENSE NU	MBER	29d, DATE	SIGNED (Month, Day, Year)	
6 5 5 M	- 11	MILIO	W/11/11	/		D19550		▶ (a)	11/90	
11	2	30. NAME AND ADDITION OF PERSON WH							W - V	
0.01		Neil A. Meade, M	.D. 9811 Ma	llard Dr	ive, Lau	rel, Mar	yland 2	20708-317	9	
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN							
		JUN 1 9 1995 Ju	ha d'avelor hard	Call						



DIVISION OF VITAL RECORDS, P.O. BOX 88780	D 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	pital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ed for use as the burial-transit permit. Pages 1, 2, 3 should
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	EALTH AND N	MENTAL HYGIENI REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	ELIZABETH	RUTH LINEBE	ERRY			June 25	5. 1995	7:20 P.M
	4. SOCIAL SECURITY NUMBER				IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRT	NPLACE (State or Foreign
	220-24-4149	8 YRS.	MONTHS DAYS	HOURS MIN.	Feb. 5, 19	927 Ma	ryland	
	9e. FACILITY NAME (If not institution, give str		9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN					
P P	503 East MacPhail	. Rd.		Bel	Air		Harfo	rd
ᇤ	RESIDENCE OF DECEDENT 10a. STATE 16b. COUNTY	10c CITY	TOWN OR LOCATI	ION				
DIRECTOR	Maryland	100.011,		el Air			10d. INSIDE CITY LIMITS?	
	10e. STREET AND NUMBER	Harford			ZIP CODE		10g CITIZEN OF	1 ☐ YES 2 🔀 NO WHAT COUNTRY?
FUNERAL	5	03 East MacI	Phail Road	Б	21014	1		USA
2	11. MARITAL STATUS	12. WAS DECEDENT EVER IF	U.S. ARMED	13. WAS DECI	ENDENT OF NISPAN	IC ORIGIN? (Specify Yes	or No.— 14. RAC	E — American Indian.
BY F	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES			elfy Cuben, Mexican 2 57 NO Specify:	n, Puerto Rican, etc.)	Spec	ck, White, etc.
	11							white
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)	(Give kind of wo	SUAL OCCUPATION of done during mos retired.)	N at of working	16b. KIND OF BUS	INESS/INDUSTRY	
PE	Elementary/Secondary (0-12)	College (1-4 or 5+)		Homemake			TTomo	
O	17. FATNER'S NAME (First, Middle, Last)			nonenake		ME (First, Middle, Maiden S	Home	
U U	William Richard	Evans				Irene Give		
8	19e. INFORMANT'S NAME (Type/Print)	2702.0	19b. MAILING A	DDRESS (Street or		loute Number, City or Town		
2	Betty R. Lineberr	y				el Air, Mai		21014
	20e, METNOD OF DISPOSITION 1 52 Burlel 2 Cremetton 3 Remo	206	PLACE AND DATE OF	DISPOSITION /Nan	ne of	DATE 200 LOC	CATION - City or T	own State
	4 Donation 5 Other (Specify)	Be	el Air Mer	morial (Gardens 6	5/28/95 Be	el Air,	Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICE	INSEE		22. NAME AN	D ADDRESS OF FAC	PILITY		
	Mesly 1	2 Odwards				mas III Fu		
	23. PART i. Enter the diseases, or co	omplications that caused	tha death. Do no	t antar the mod	la of dylng, auch	Road, Abi	ratory arrest.	Md. 21009 Approximate
	shock, or heart failure. L	ist only one cause on e	ach lina.					interval Between Onset and Death
	disease or condition resulting in death)	URE	MIA					3 WEEKS
Ì			CONSEQUENCE OF):					
Z	Sequentially list conditions,				FAILU	RE		/ YETHR
Ĕ.	or the second trops, leading to immediate cause. Enter UNDERLYING CALISE (Disease or injury) C. C. CALISE (Disease or injury) C. C. C. C. C. C. C. C. C. C. C. C. C. C							5 YEARS
FIC	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):	LUMEP	(UZOJCZ	E820317		2 18111
CERTIFICATION	resulting in death) LAST			ENDE	NT DI	ADSETES		25 YEARS
	0.							7,5 . 5///(5
ÄL	PART II. Other significent conditions	contributing to death be	ut not reaulting in	the undariying	cause given in F	Part i. 24s. WAS AN A		D. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
ĕ	HYPOTHY					1 YES 2	ATNO	COMPLETION OF CAUSE OF DEATH?
M	HYPERTE					_		1 TES 2 NO
AN	DID TOBACCO USE CONTR				UNCERTAIN			
PHYSICIAN: MEDIC	EXAMINER?	HOSPITAL:	28. PLACE OF DEATH	OTHER:				
¥	27. MANNER OF DEATH	1 Inpatient 2 ER/Outp	28b. TIME (5 Residence 6	28d, DESCRIBE HOW IN	HIRV OCCURED	
	1 Netural 5 Pending	(Month, Day, Year)	INJUR	NOW WOR		200. DESCRIBE HOW IN	JUNY OCCUMED	
) BY	2 Accident Investigation 3 Suicide 6 Could not be	26e. PLACE OF INJURY	— At home, farm, stre			28t. LOCATION (Street or	nd Number or Rural i	Route Number.
Ē	4 Homicide determined	building, etc. (Spec.	пу)			City or Town, State)		0.0000000
COMPLETED	29e. CERTIFIER (Check only	IAN: To the best of my knowl	edge, death occurred	at the time date of	and place, and due t	n the country and many	arcontes.	
N N	one) 2 MEDICAL EXAMINER	: On the baels of examination	and/or investigation,	In my opinion, de	ath occured at the ti	ime, date end place, end	due to the cause(e) end manner as stated.
	296, SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUME			(Mgnth, Dey, Year)
BE	Ander No	evolcom	- ms		DOS		► 6/27	9/9J
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	ITN (ITEM 27) (Type, Pi	rint)			1 1	21014
	ANDREW NO	OW AKOWSK	=1, m	D.	125 1	V. MAIN	57. 8	ELAIR, MD
	31. DATE FILED (Month, Day, Year)	12. REGISTRAR'S SIGNI	TURE					
	JUN 2 8 1995	jahr Davidson	Nardall					
	<u> </u>	,						

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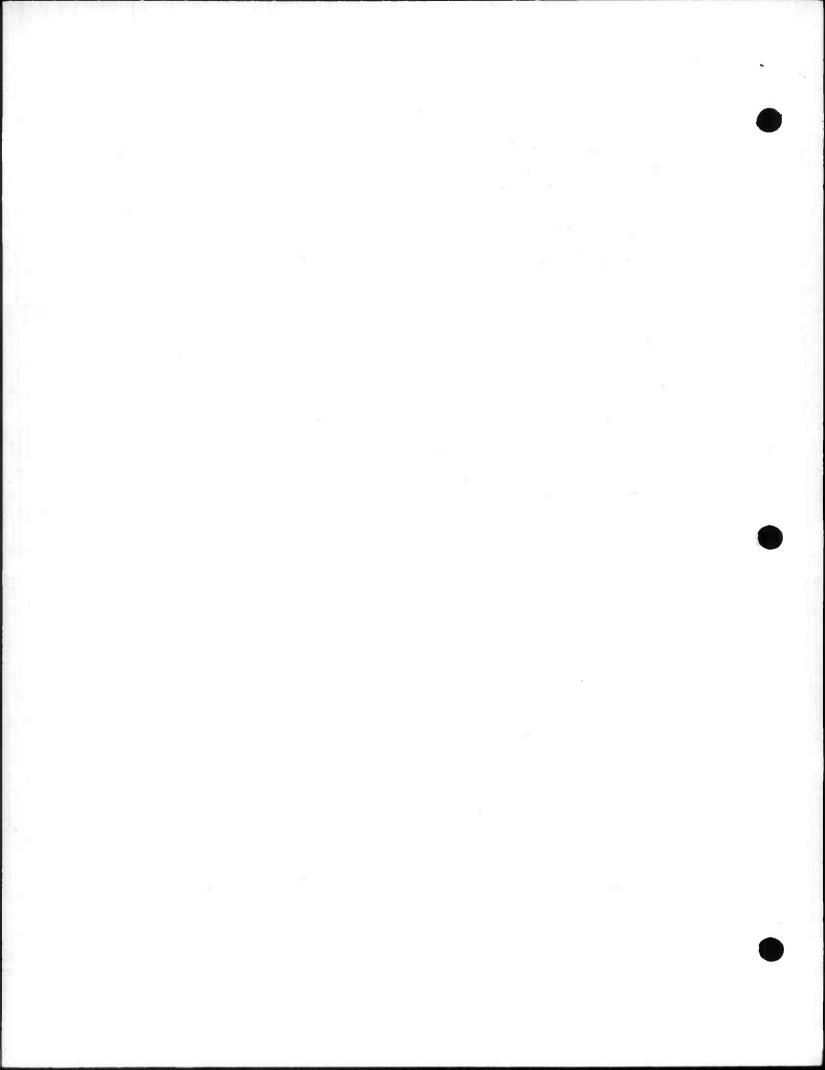
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

recuted within 24 hours after death. Page 6 may be retained by the hospital or attending physic	and completely filled in by the funeral director, page 5 should be detached for use as the burial burial, cremation, or removal.	the matery of the residual average land assumed to a material and and
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within \$74 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked or item 23 shows and injury or other fraums

31. DJUNE2/1911/1995 Julia States States States

									9	0 6	10669
	1 - FOR STATE REGISTRAR	STATE OF N	MARYLAND C	DEPAR	TMENT O	F HEALTH AND	MENT	TAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)		Sidne	ev Da	rrell	Lease		TE OF DEATH			3. TIME OF DEATH
	S'IONE-	LEA	SE	c, Du	11011	Dease	MO	NE 2		YEAR	17:10 (PM
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la	st birthday)	IF UNDER 1 YE	AR IF UNDER 24 HRS.	7. DA	TE OF BIRTH		8. BIRTH	PLACE (State or Foreign
	215-26-2179	1 🖟 M 2 🗆 F	71	YRS.	MONTHS DA	TE HOURS MIN.	(M	onth, Day, Ybar)	023	Country	ryland
	9e. FACILITY NAME (If not institution, give a	treet end number)			9b. CITY, TO	VN OR LOCATION OF		-1.01, 1		INTY OF D	
5	Northwest Hospit	al Cente	r		D.	ndallstow					
15	Northwest Hospit	di ochice.			Na	IIdalistow	/11		1	Dait	imore
DIRECTOR	10e. STATE 10b. COUNT	•		10c. CIT	Y, TOWN OR L	CATION					10d. INSIDE CITY LIMITS?
	Maryland Carr	o11			New Wi	ndsor					1 X YES 2 NO
₹ X	10e. STREET AND NUMBER					101. ZIP CODE			10g. CIT	IZEN OF W	HAT COUNTRY?
FUNERAL	103 Blue Ridge Av					21776			U.S	. A.	
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDEN	T EVER IN U.S. A	RMED NO	13. WAS	DECENDENT OF HISP , specify, Cuban, Mexi	ANIC ORI	GIN? (Specify Yes	or No—	14. RACE	— American Indian, White, etc.
ВУ	3 Widowed 4 Divorced	IF YES, GIVE W			10	YES 2 NO Spe	cify:	to ricen, etc.)		Specif	White
ED	15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY										
ETE	(Specify only highest grade	completed)	(0	ive kind of a	words along abusin	most of working	- []	16b. KIND OF BUS	INESS/ING	DUSTRY	
1	Elementary/Secondary (0-12)	College (1-4 or 5 +	,	arme				D			
COMPL	17. FATHER'S NAME (First, Middle, Last)		1	arme	1			Dai			
	Samuel G. Lease								Sumeme)		
BE	10e INFORMANTIS NAME (Transferrit										
임	Dorothy H. Lease 103 Blue Ridge Ave New Windsor, Md. 21776										
					OF DISPOSITION			ATE 20c. LO			
	20a. METHOD OF DISPOSITION 1	oval from State	cemetery, cre	ematory or o	ther place)	t name or					
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	Trhe	Cree	22. NAM	E AND ADDRESS OF	D/Z	25 Nr.	New	Wind	sor. Md.
	() () (100	7111			E AND ADDRESS OF J					
	/ellal	X A	coluber					ndsor, N			
	23. PART I. Enter the diseases, or a shock, or heart fellure.	Dmplications that List only one cau	caused the da	eth. Do r	ot enter the	mode of dying, au	ich aa ci	ardiac or reapi	ratory an	reat,	Approximate interval Between
	IMMEDIATE CAUSE (Final										Onset and Death
	disease or condition resulting in death)	a. GA DUE TO	STRIC	<	ARC	ASTON 1.					6 YEARS
		DUE TO	(OR AS A CONSE	QUENCE O	F):						
8	Sequentially list conditions.	b									
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	DUE 10	OR AS A CONSE	OUENCE OF	7):						
윤	CAUSE (Disease or injury that initiated events	DUE TO	OR AS A CONSE	OHENCE OF	D.						
틽	resulting in death) LAST		14		,.						Ì
핑		d									·
A.	PART II. Other algnificent condition	a contributing to	death but not i	reaulting	n tha under	ying cause given i	n Part I.	24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS
MEDICAL								1 TYES 2			AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
NE I											1 TYES 2 NO
ä	DID TOBACCO USE CONTI	RIBUTE TO CA	USE OF DEA	TH YE	S I NO	☐ UNCERTA	IN 🗆				
SIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLAC	E OF DEAT	'H (Check only o	ne)					
SI	1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)										
PHYSICIAN:	27. MANNER OF DEATH	26e. DATE OF (Month, Da		26b. TIM	E OF 28c.	INJURY AT WORK?	28d. D	ESCRIBE HOW IN	JURY OC	CURED	
BY	1 Natural 5 Pending 2 Accident Investigation	1930	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			YES 2 NO					
	3 Suicide 6 Could not be	26e. PLACE OF building.	INJURY — At ho	me, ferm, s	traet, fectory, e	ffice	261. LC	OCATION (Street e	nd Number	or Rural Ro	oute Number,
	4 Homicide determined	N	1 4					ly or lown, oleto,			
PL	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of	my knowledge, de	ath occurre	d at the time,	late end place, and du	e to the o	cause(e) and man	ner ee stat	led.	
COMPLETED	one) 2 MEDICAL EXAMINE										end manner ee stated.
Ü	29b. SIGNATURE AND TITLE OF CERTIFIER					29c, LICENSE NI	JMBER		29d, DAT	E SIGNED	(Month, Day, Year)
₾	1CM2 18.5	· RAD · M	.0					2	D 3	. UNE	21 1995
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUS	E OF DEATH (ITE	M 27) (Type,	Print)						
- 1	K.S. RAO. 714) NOBI	H WEST	He	SPITA	C CEN.	TER	RAC	AQI	500	TOWN, MID



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

	REGISTRAR		CERTIF	TOATE	JE DEATH	_	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Lest) NELSON L.	I.	ANDON			2. DATE MONT 06	of DEATH D	199	YEAR 8	3. TIME OF OEATN B:30 p m
	4. SOCIAL SECURITY NUMBER 218-16-7252	5. SEX 6. AGE	71 YRS.	IF UNDER 1 YE MONTHS DA	AR IF UNDER 24 HRS. AYS HOURS MIN.	7. DATE (Mon	th, Day, Year)		8. BIRTHPL Country)	RYLAND
E	90. FACILITY NAME (II not institution, give McCready Foundati			9ь. city, то	WN OR LOCATION OF	DEATH		Some	TY OF OEA	
CTOR	RESIDENCE OF DECEDENT							L		
DIRE	MARYLAND SOME	RSET	100	INCESS						Od. INSIDE CITY LIMITS? X YES 2 NO
ERAL	100. STREET AND NUMBER 11540 BECKFORD AV	/ENUE		····	10f. ZIP CODE 21853				S. S.	AT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT, EYER FORCES? 1 YES IF YES, GIVE WAR OR	8 2 NO	II yes	DECENDENT OF HISP e, specify Cuban, Maxi YES 2 NO Spec	can, Puerio	N? (Specify Yes Rican, atc.)		14. RACE - Black, \ Specify:	American Indian, white, etc.
ED	15. DECEDENT'S EDU (Specify only highest grade		16a. DECEDENT'S	USUAL OCCU	PATION	166	b. KINO OF BUS	SINESS/INOL		WITTE
IPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	OWNER/N	se retired.)	g most of working		AIR CON	וחדדדת	NITNO	
COMPL	17. FATNER'S NAME (First, Middle, Last)				18. MOTHER'S I				MILING	
BE	TALMAGE LANDON				SUSIE					
70	19a. INFORMANT'S NAME (Type/Print) SALLY STEELE		1		TE CREEK R					10050
	20e. METHOD OF DISPOSITION 1	ioval from State C6	06. PLACE AND DATE emetery, crematory or C SALISBURY	OF DISPOSITIO	N (Name of	DAT	7E 20c. LO	CATION C	aty or Town	n, State
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	DALISBURY	22. NAM	E AND ADDRESS OF			TZRUE	RY, M	ARYLAND
	James 9. He		00295	PR	NMAN FUNE	NE M	ID 218	153		
	23. PART I. Enter the diseases, or shock, or heart feilure. IMMEDIATE CAUSE (Finel disease or condition soutting in death)	List only one cause on	ed the death. Do aach line.	not enter tha	at.	1				Approximate Interval Between Onset and Death
NO	Sequentially list conditions,	. mult.	A CONSEQUENCE O	SOJE	ernons C	ell	Car	cin o.	mag	yrs
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	c. DUE TO (OR AS	A CONSEQUENCE O		ramous Rf	Cell	Car. 11 6	cine	ma	monthy
Ä	resulting in death) LAST	a. 6 i av.	bete	3						2 TY.
	PART II. Other aignificent condition	na contributing to deeth	but not resulting	In the under	lying cause given i	n Part I.	24e. WAS AN			PERE AUTOPSY FINDINGS
EDICAL							PERFOR	_	C	WAILABLE PRIOR TO OMPLETION OF CAUSE IF DEATH?
SICIAN: M	DID TOBACCO USE CONT	RIBUTE TO CAUSE (OF DEATH Y	ES NO	UNCERTA	IN 🗆			1 '	YES 2 NO
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA							
IXSI	1 D YES 2 NO	1 Denpetient 2 ER/Our		4 Nursing	Nome 5 - Residence	1				
ву Рну	1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	in.	JURY M 1	WORK?	28d. DE	ŞCRIBE HOW II	NJURY OCCI	URED	
ETED	3 Suicide 6 Could not be 4 Nomicide determined	28e. PLACE OF INJUR building, etc. (Spi	28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, stc. (Specify)			281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			te Number,	
COMPLI		CIAN: To the best of my kno								nd manner se stated,
BE	29b. SIGNATURE AND TITLE OF CERTIFIE	1X	enhav		29c. LICENSE N	JMBER 76	1	29d. DATE	SIGNEDIM	Seld C
10	30. NAME AND ADDRESS OF PERSON WE Madhav D. Barhan	, MD 43	EATH (ITEM 27) (Type 84 Crisf	ield Hi	ighway	Cr	isfiel	d, Md	. 218	317
	JUN 2 8 1995		RE		-	-				
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COMPLETED BY PHYSICIAN: MEDICAL

38 2 3 Suicide

4 Homicide

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2.1 ours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. or other traumatic event, the medical examiner must be notified at IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury,

								9	5	20671
	FOR STATE REGISTRAR	STATE OF M			TMENT OF I		MENTAL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last) William P. Mass						June 27		995	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 218-70-0123	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) June 3, 1	958	Count	HPLACE (State or Foreign ny)				
HOLO	90. FACILITY NAME (If not institution, give 4001 Old Columb, RESIDENCE OF DECEMENT					on Location of D ott City	EATH		HOW	
DIREC	10a. STATE 10b. COUNT	oward			TOWN OR LOCA					10d. INSIDE CITY LIMITS? 1 YES 2 NO
LENAL	4001 Old Columb					21043		Uı	nite	MHAT COUNTRY?
פע דטר	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	TEVER IN U.S. ARI YES 2 N N N N N N N N N N N N N N N N N N N	13. ARMED 2 NO 13. WIS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:						14. RACE — American Indian, Bleck, White, stc. Specify: White	
IFLEIED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)	·) (Gi	CEDENT'S We kind of w Do NOT us Pive	USUAL OCCUPATI work done during m be retired.)	ON ost of working	16b. KIND OF BU			CV	
SE CON	17. FATHER'S NAME (First, Middle, Last) Charles Albert I	Massey Sr		6,			ame (First, Middle, Malden cia M. Kerl			
2	Patricia K. Mas:	sey	4	1001	Old Col	umbia Pil	Route Number, City or You ke Ellicot	t Cit	ty MI	
	28e. METHOD OF DISPOSITION 1 XBuriel 2 Cremation 3 Res 4 Donation 6 Other (Specify)		other ple	100)	wn Memo		6-30 Mai		- City or T LLSVi	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE						zke Funera			Inc. : City 21043
	23. PART I. Entar tha disease, or shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death)	. List only one cau	ise on each line		not anter tha m	oda of dying, su	ch as cardiac or raap	iratory a	rrest,	Approximeta Interval Between Onset and Death A 3 works
AIION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSEC	DUENCE O	F):		LIVER			
EHILLICA	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST	cDUE TO	(OR AS A CONSEC	QUENCE O	F):					
٥										1

PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one)

24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY PERFORMED? 1 | YES 2 NO

1 | YES 2 | NO

HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 TES 2 NO 28s. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 5 Pending Investigation 1 Natural 2 Accident

6 Could not be determined

OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) 28b. TIME OF INJURY 28c. INJURY AT WIA 1 YES 2 NO

28d. DESCRIBE HOW INJURY OCCURED NA

28e. PLACE OF INJURY — building, etc. (Specify) ome, farm,

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER
(Check only one)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner se stated.

2 ____ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. LICENSE NUMBER 241139 29d. DATE SIGNED (Month, Day, Year)

• 6/29/95 296. SIGNATURE AND TITLE OF CERTIFIER

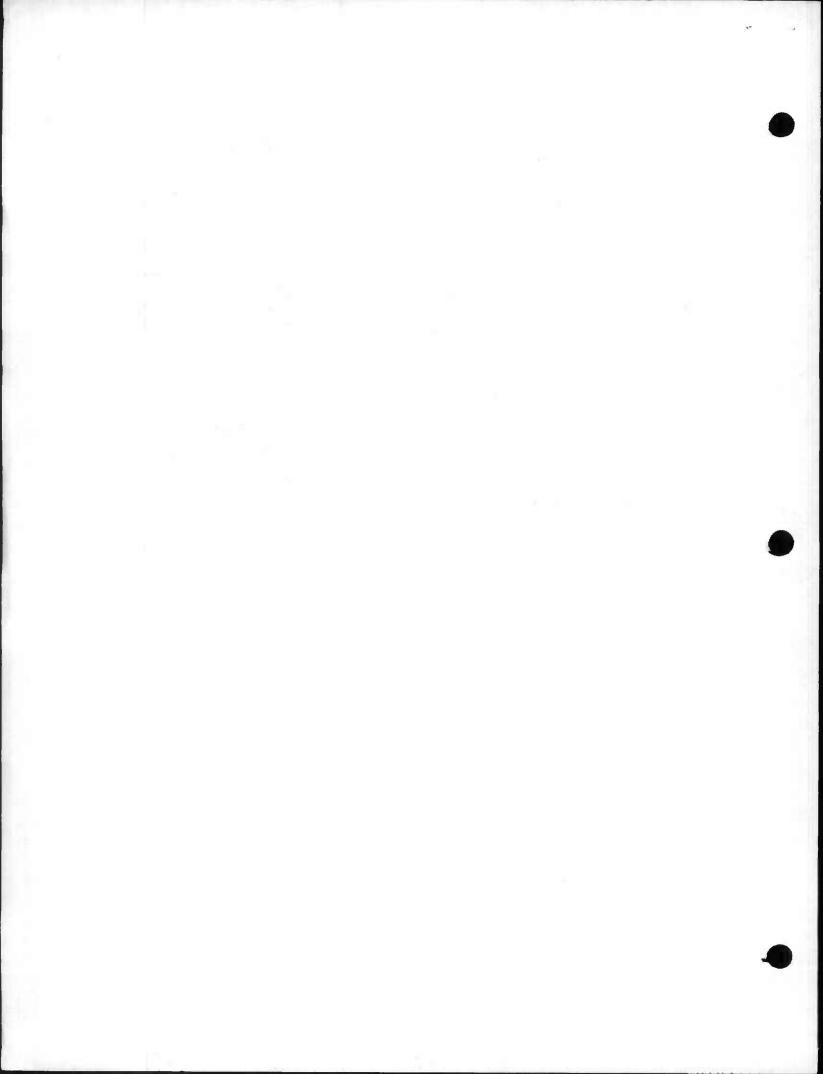
CIS	(Cight	u).	
30. NAME AND ADDRESS	OF PERSON WHO COMPLETE	D CAUSE OF DEATH (IT	EM 27) (Type, Print
11062 T	etch Put	uxent	Park

Parkway

2104

JUN 2 9 1995

32 medistraps sychotoms. Felia d'hurcleon Ravolall



	1 - STATE REGISTRAR	SIAIE UP MA	CERTIF					MENIAL H	EG. NO.	:		
0.000	1. DECEDENT'S NAME (First, Middle, Last) LORA ETT	A MATTE	IEWS					2. DATE OF I		199	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 220-28-4716	5. SEX 6.	AGE (In yrs. last birthday) 89 YRS.	IF UNDER 1		IF UNDER	24 HRS. MIN.	7. DATE OF E			8. BIRTH	GINIA
	9a. FACILITY NAME (If not institution, give :	street end number)		9b. CITY, 1	TOWN OR	LOCATIE	N OF DE		9c. CDU	NTY OF DE		
DIRECTOR	Salisbury Nursing	& rehab (Center	Sali	sbur	У,	Md.			Wic	omic	
EC	10e. STATE 10b. COUNT	Y	10c. CIT	Y, TOWN OR	LOCATION	N						10d. INSIDE CITY
	MARYLAND WORCE	ESTER	POC	OMOK!	E CI	TY						1 YES 2 ND
FUNERAL	100. STREET AND NUMBER 27 BRADLEY CT.				101. Z	851				UNI		STATES
BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 _ IF YES, GIVE WAR	YES 2 NO	H :	AS DECEN yes, specif YES 2	fy Cuber	, Mexices	IIC ORIGIN? (S n, Puerto Ricar :	pecify Yes (or No-	Black,	— American Indian, White, etc. BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working												
COMPLETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +)											
Tr. FATHER'S NAME (First, Middle, Lest) JAMES ED. MATTHEWS 18. MOTHER'S NAME (First, Middle, Meiden Surname) CLORA TAYLOR												
TO E	190. INFORMANT'S NAME (Type/Print) BEULAH BAYLES		196. MAILING 103	FRON!	Street end	Number	or Rural R	Noute Number, C	CIT	State, Zip	Code)	
	204 METHOD OF DISPOSITION 1 Suriel 2 Cremetton 3 Rem 4 Donation 5 Other (Specify)	ioval from State	20b. PLACE AND DATE	OF DISPOSIT	ION (Name			6/6/			City or Tow	
	21. SIGNATURE OF FUNERAL SERVICE LI	ENSEE / Short	1/2	WH.	ARTC	ADDRES		CILITY				
\neg	23. PART I. Enter the diseases, or	complications that co	aused the death. Do	not enter th	2171	of dule	IAR.	ION RI	J. A	CCO	MAU,	
	shock, or heart fallure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	a	A CONSEDUENCE O	cers					or reapire	atory arr		Approximate Interval Between Onset and Deat
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEDUENCE OF): c. DUE TO (OR AS A CONSEDUENCE OF):											
CAL	PART II. Other algoriticent condition	as contributing to de		in the unde	erlying c	euse gi	ven in i		WAS AN A	ED?		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
MED	VAgue	- Relax	Resoul	// >	, 6	67	2,0	_ ''	YES 2	NO		OF DEATH?
N.	DID TOBACCO USE CONT				0 🗆	UNCE	RTAIN	10				
	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	H (Check onl	ly one)							
PHYSICIAN:	1 YES 2 NO	1 Inpatient 2 ER		4 Nursin			idence i	B 🗆 Other (Spi				
BY P	1 Natural 5 Pending	28e. DATE OF INJ (Month, Day,)		URY	8c. INJURY WORK 1 YES	?	ND	28d. DE\$CRIB	E HOW IN.	JURY OCC	CURED	
	3 Suicide 8 Could not be determined	28e. PLACE OF IN building, etc.	JURY — At home, farm, s (Specify)	itreet, factory	y, office				8f. LOCATION (Street and Number or Rural Floute Number, City or Town, State)			
COMPLETED	29e. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date and place, end due to the cause(e) end manner as stated. MEDICAL EXAMINER: Dn the basic of examination and/or investigation, in my opinion, death occurred at the time, data end place, end due to the cause(s) end menner se stated.											
TO BE	296. SIGNATURE AND TITLE OF CERTIFIER M. AT. R.	ins a	2_ M	2	29		SE NUM	98C	3	29d. DATE	SIGNED (Month, Day, Year)
ŕ	30. NAME AND ADDRESS OF PERSON WH	COMPLETED CAUSE OF			יי אינוער	י חס	TVE	SALIS	יחוחי	BAT	21.0	201
	JUN 0 8 1995	Jahra Dau	SIGNATURE CHARLES	пеагл	JWAY	UK	I. V.C.	SALLS	BUKY	<u> MD</u>	<- 1.8	OOT

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

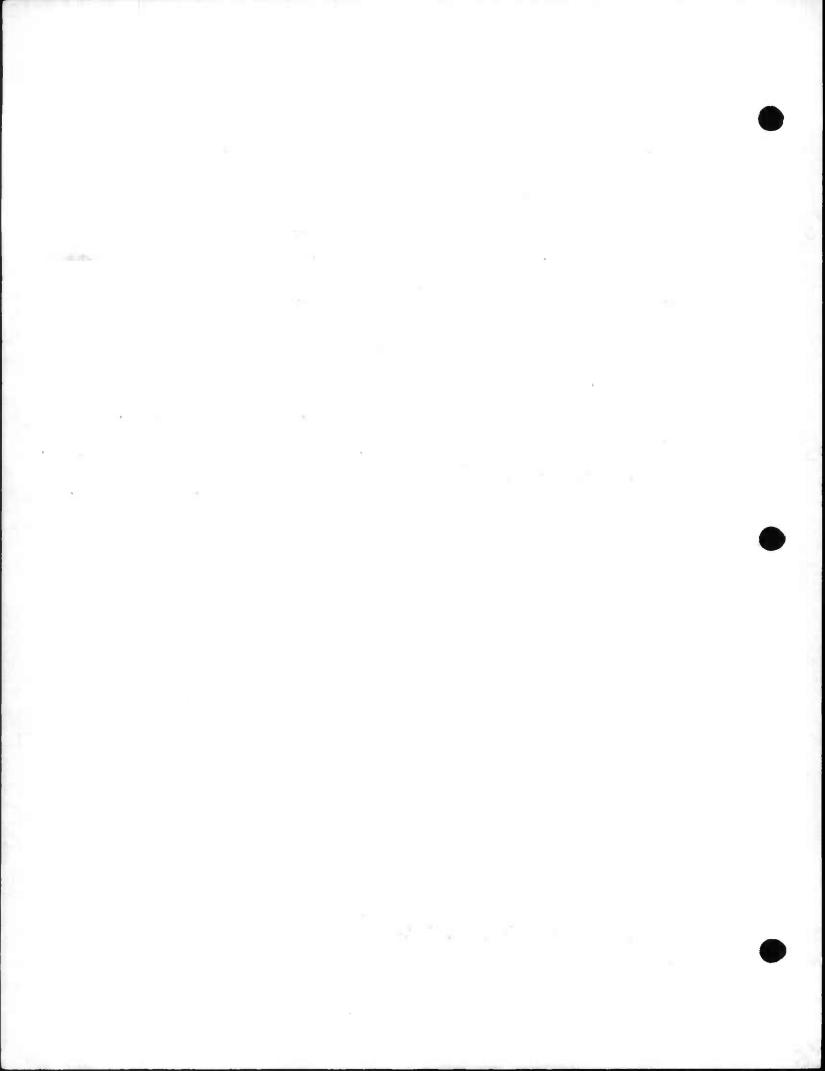
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

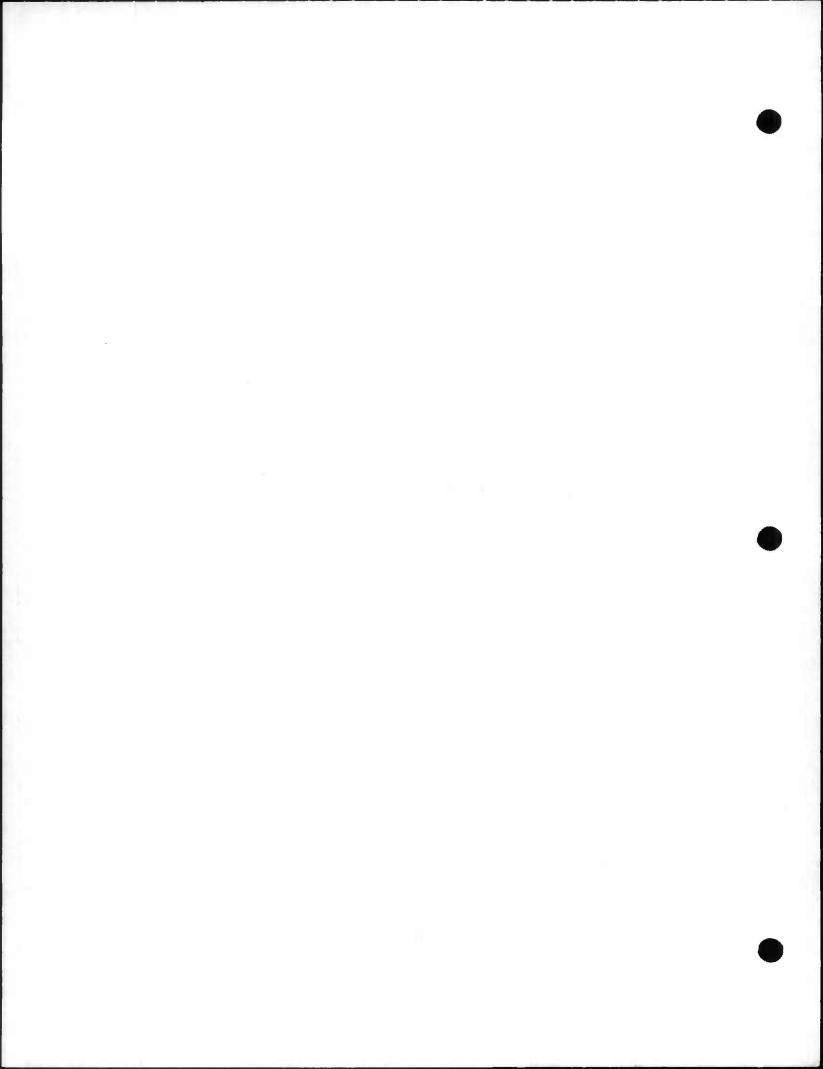


BALTIMORE, MARYLAND 21215-0020

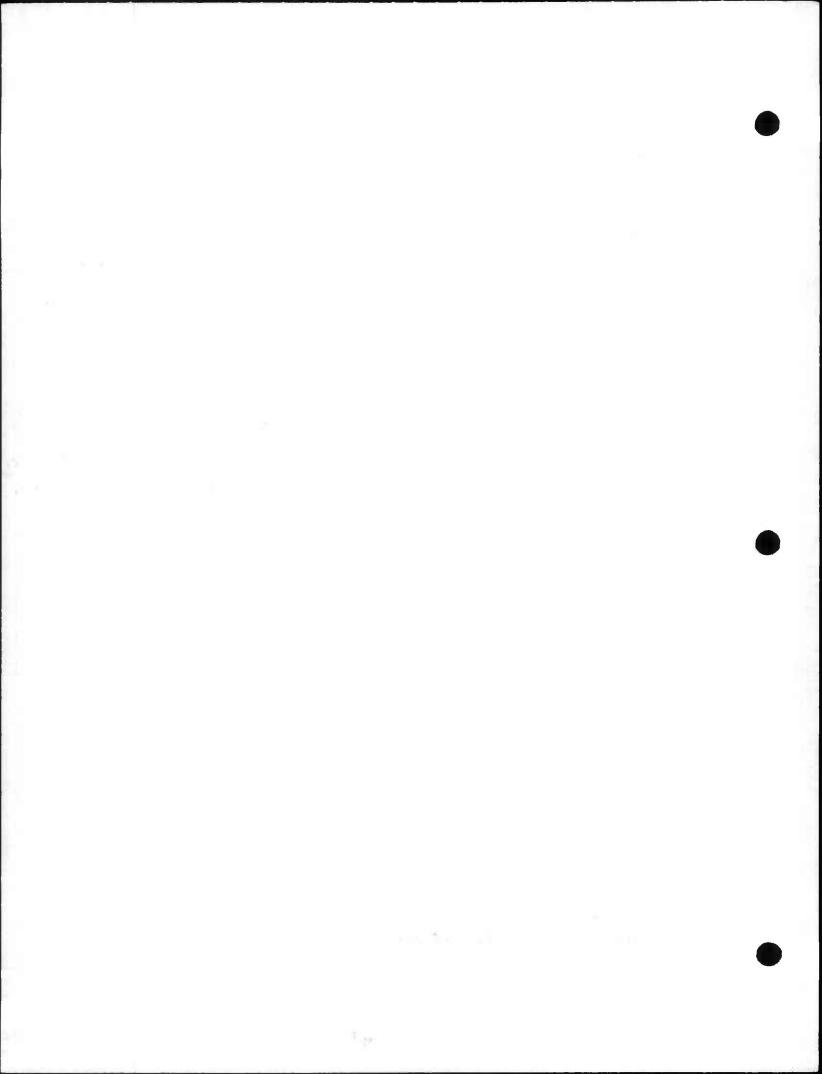
DIVISION OF VITAL RECORDS, P.O. BOX 68760

IE HOSPITAL O IE FUNERAL DI d within 72 ho	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	RECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.	ons are occur with the coale occur, or regain and receive broken broken to be made a coale occur. In terroral, or the medical examiner must be notified at once.	
MP6 TH	O THE HOSPITAL OR ATTENDING PHYSIC	TO THE FUNERAL DIRECTOR; After this cer	MPORTANT: If item 28 is marked,	

							95	20673									
	1 - FOR STATE REGISTRAR	STATE OF MARY		RTMENT OF I		MENTAL HYGIEI											
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	DAY YE	3. TIME OF DEATH									
1	ELEANOR		IPHANT	MURPH		June 14, 1	995	4:45 a м									
	4. SOCIAL SECURITY NUMBER 218-24-4016	1 🗆 M 2 🚉 F	GE (In yrs. lest birthday) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) August 5, 19	(BIRTHPLACE (State or Foreign Country) Maryland									
m	9a. FACILITY NAME (If not institution, give s			1.00	OR LOCATION OF DE	ATN	9c. COUNTY	OF DEATN									
DIRECTOR	30363 Calhoun A	ve.		Sali	sbury		omico										
Æ	10a. STATE 10b. COUNT	Y	10c. CI1	TY, TOWN OR LOCA	TION			10d. INSIDE CITY									
		omico	S	alisbury				LIMITS?									
FUNERAL	10e. STREET AND NUMBER			10	f. ZIP CODE			OF WHAT COUNTRY?									
Ä	30363 Calhoun A				21801		USA	-									
3	11. MARITAL STATUS 1 ☐ Never Married 2 ☑ Merried	12. WAS DECEDENT EVE FORCES? 1 7	ES 2X NO	If yes, sp	ecify Cuban, Maxicer	IC ORIGIN? (Specify Yen, Puerto Rican, atc.)		RACE — American Indian, Black, White, etc.									
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OF	R DATES	1 TYES	2 K NO Specify			White									
ED	15. DECEDENT'S EDU (Specify only highest grade		18a. DECEDENT'S	USUAL OCCUPATI	ON	16b. KIND OF BU											
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 17. FATNER'S NAME (First, Middle, Last) 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKET 18a. MCTNER'S NAME (First, Middle, Malden Surname)																	
Ö,	17. FATNER'S NAME (First, Middle, Last)					ME (First, Middle, Maider											
Stewart Oliphant Marguerite Baumgartner																	
19b. MAILING ADDRESS (Street and Number or Rurel Route Number, City or Town, State, Zip Code)																	
20s. METHOD OF DISPOSITION 20b DI ACE AND DATE OF DISPOSITION (Alternation of DATE 20c LOCATION City of Time State																	
1 \(\text{XBuriel 2 \(\text{Cremetion 3 \(\text{Denotion 6 \(\text{Other}(Specify) \)} \) \(\text{Other (Specify) \) \(\text{Other (Specify) \)} \) \(\text{Other (Specify) \) \(\text{Other (Specify) \)} \) \(\text{Other (Specify) \) \(\text{Other (Specify) \)} \) \(Other (Specify) \) \(\text{Other (Specify) \) \) \(\text{Other (Specify) \) \(\text{Other (Specify) \) \) \(\text{Other (Specify) \) \(\text{Other (Specify) \) \) \(\text{Other (Specify) \) \) \(\text{Other (Specify) \) \) \(\text{Other (Specify) \) \(\text{Other (Specify) \) \) \(\text{Other (Specify) \) \) \(\text{Other (Specify) \) \(\text{Other (Specify) \) \) \(\text{Other (Specify) \) \(\text{Other (Specify) \) \) \(\text{Other (Specify) \) \(\text{Other (Specify) \) \) \(\text{Other (Specify) \) \(\text{Other (Specify) \) \) \(\text{Other (Specify) \) \) \(\text{Other (Specify) \) \) \(\text{Other (Specify) \) \(\text{Other (Specify) \) \) \(\text{Other (Specify) \) \) \(\text{Other (Specify) \) \) \(\text{Other (Specify) \) \) \(\text{Other (Specify) \) \(\text{Other (Specify) \) \) \(\text{Other (Specify) \) \) \(\text{Other (Specify) \) \) \(\text{Other (Specify) \) \(\text{Other (Specify) \) \) \(\text{Other (Specify) \) \(\text{Other (Specify) \) \(\text{Other (Specify) \) \\ \end{tabular \) \(\text{Other (Specify) \) \\ \end{tabular \) \(\text{Other (Specify) \) \\ \text{Other (Specify) \) \\ \end{tabular \) \(\text{Other (Specify) \) \\ \text{Other (Specify) \) \\ \end{tabular \) \(\text{Other (Specify) \) \\ \end{tabular \) \(\text{Other (Specify) \) \\ \end{tabular \) \\ \text{Other (Specify) \) \\ \text{Other (Specify) \) \\ \end{tabular \) \\ \text{Other (Specify) \) \\ \end{tabular \) \\ \text{Other (Specify) \) \\ \text{Other (Specify) \) \\ \end{tabular \) \\ \text{Other (Specify) \) \\ \end{tabular \) \\ \text{Other (Specify) \) \\ \text{Other (Specify) \) \\ \end{tabular \) \\ \text{Other (Specify) \) \\ \text{Other (Specify) \) \\ \text{Other (Specify) \) \\ \text{Other (
21. SIGNATURE OF FUHERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY																	
	MIKEVER	In Word	20 -			neral Home		MD 01001									
	25. PART I. Enter the disesses, or	complications that cau	sed the deeth. Do	not enter the mo	onow HII	LI KO., Sa	lisbury	y, MD 21801									
	shock, or heart fallure. iMMEDIATE CAUSE (Finsi	List only one cause or	n each fina.				, , , , , , , , , , , , , , , , , , , ,	Interval Between Onset and Death									
	disease or condition resulting in desth)	. A	6 do mina	1 50	rcoma			840.									
		DUE TO (OH A	S A CONSEQUENCE O														
NO	Sequentielly list conditions,	b. DHE TO YOU A	S A CONSEQUENCE O														
Ă	If sny, leading to immediate cause. Enter UNDERLYING	502 10 (011 %	o A CONSECUENCE C	T).													
F	CAUSE (Disease or Injury that initiated events	DUE TO (OR A	S A CONSEQUENCE O	F):													
CERTIFICATION	resulting in death) LAST	d															
- I	PART ii. Other significent condition	ns contributing to deati	h but not resulting	In the underlyin	a cause given in I	Part I. 24a, WAS AF	AUTOPSY	24b. WERE AUTOPSY FINDINGS									
2	Aurmia of	Chanie Ds			•	PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE									
ED I	Hx. Cardiac	Arryth.	2, ~			1 TYES	2 110	OF DEATH?									
2 :	DID TOBACCO USE CONTI	RIBUTE TO CAUSE	OF DEATH Y	ES NO [UNCERTAIN	<u></u>		T TES 2 NO									
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA														
YSI	1 TES 2 0010	1 Inpetient 2 ER/O	Outpetient 3 DOA	OTHER: 4 - Nursing Non	ne 5 AResidence	6 Other (Specify)											
PH	27. MANNER OF DEATN 1 Natural 5 Pending	28a. DATE OF INJUR (Month, Day, Yea		JURY WO	URY AT	28d. DESCRIBE NOW	INJURY OCCURE	:D									
2 Accident Investigation M 1 YES 2 NO																	
3 Suicide 4 Homicide 5 Could not be determined 5 CERTIFIER (Check only one) 298. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 298. CERTIFIER (Check only one) 299. CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 299. CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.																	
									1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1								14/91
									2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF	DEATN (ITEM 27) (Type	, Print)			4/	. 1/
										Cosc, 1	illy 106	milford	54. 5	alisbun	md. 21	801	
	JUN 15 1995	Filia d'unde	or harlall														



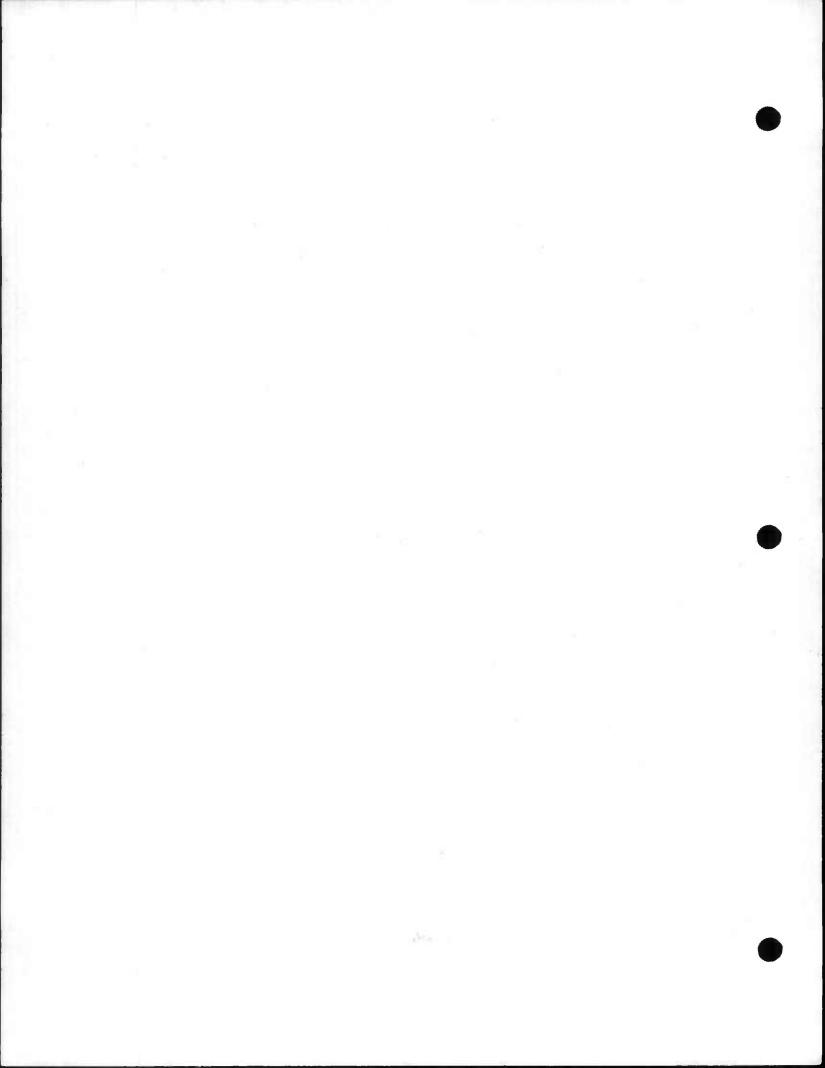
		REGIOTIAN				OLITT	110/	AIL O	L DEA	1111		HEG. NO.			
		1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF MONTH	DEATH	v	YEAR	3. TIME OF DEATH
													1995		11:10 P. M
		4. SOCIAL SECURITY NUME		5. SEX		rs. last birthde		UNDER 1 YEA	R IF UNDE	R 24 HRS.	7. DATE OF	BIRTH		8. BIRTH	PLACE (State or Foreign
		219-36-50	06	1 🗌 M 2 🔀 F	5	3 YAS	MON	THS DAY	HOURS	MIN.	5-9	- 1°94	2	Country	ARYLAND
Dinou		9a. FACILITY NAME (If not in	stitution, give st	reet and number)			9b.	CITY, TOW	N OR LOCAT	ION OF D	EATH		9c. COUN		
permit. Pages 1, 2, 3 should	B	Salishury	Murcir	og & Poh	h Con	enter Salisbury						T47	icom	ni ao	
7	DIRECTOR	Salisbury RESIDENCE OF DEC			ID CEL					<u>v</u>			W	TCOII	псо
Safte	8	10e. STATE	10b. COUNTY			10c.		WN OR LO							10d. INSIDE CITY LIMITS?
Ĭ.		MD.	MIC	OMICO			SA	LISE	URY						1 TES 2 NO
Ē.	¥	10e. STREET AND NUMBER	T O M 2	6 1431 00	OMO	MOD	D 3	D. 7.	101. ZIP COI						HAT COUNTRY?
20	FUNERAL		LOT Z	6 WALST	LONZ	MOB.	PA	RK	21	801				U.S	• A •
12	5	11. MARITAL STATUS 1 Never Married 2	Mandad	12. WAS DECEDEN FORCES? 1	T EVER IN U.	S. ARMED		13. WAS E	ECENDENT Specify Cub	OF HISPAI	NIC ORIGIN? (S	Specify Yee	or No-	14. RACE Black	— American Indien, , White, atc.
	Β	3 Widowed 4 N Divo		IF YES, GIVE W					ES 2 X NO			,,		Specif	
2		15 DEC	EDENT'S EDUC	CATION	14	In DECEDEN	rie Hell	AL COCUR	7:01					lasari	
OSO OSO	ETED	(Specify onl	y highest grade	completed)		Give kind life. Do NO	of work o	done during	most of work	ing	16b. Kil	ND OF BUS	INESS/INDU	JSTRY	
2	12	Elementary/Secondery (0	3-12)	College (1-4 or 5	+)			ITY				HOS	PITA	Τ.	
once.	COMPL	17. FATHER'S NAME (First, M	liddle (ast)			013	J () I (111	T 40 MG	FUEDIO NA	ME (First, Midd				
at o		HERMAN		Y							A ANN				
	BE	19a. INFORMANT'S NAME (Type/Print)			T 10h MAII	NG ADD	DECC /Crm			Route Number,			Codel	
notified	임	KEN MORL									LEWES				R
9		20a, METHOD OF DISPOSIT	ION		200 PI	ACE AND DA				DI.	OATE	-	CATION — C		
must		1 X Burial 2 Crematic		rval from State	cemete	ARSO			TERY		6-19				Y,MD.
196		21. SIGNATURE OF FUMERA		ENSEE /	. /	AKOO!	1		ANO ADDR				ADIO	DOK	I / FID •
or removal. medical examiner		1	#1		41		- 1		OIMID	e bi	TATION A 1		ME	CAT	TODUDY NO
al ex	\Box	XCH	1.	for	un								-		ISBURY, MD.
or remova	1	#3. PART I. Enter the shock, or h	eart,/bilupe	omplications that List only one cau	t ceused the	ne deeth. D h line.	o not e	enter the	mode of dy	ying, suc	h es cardiac	or respli	ratory arre	est,	Approximate Interval Between
the m	Q	MMEDIATE CAUSE (FIR	nal	_			_								Onset and Death
matic		disesse or condition resulting in death)	→ ,	PRO DUE TO	6A36	a A	SPI	12477	on f	Paleu	mon17	75			140Ays
and Mental Hygiene prior to burial, cremation, y Injury, or other traumatic event, the				DUE TO	(OR AS A CO	ONSEQUENCE	OF):		1						4/
traumatic	N	Sequentielly list condit	ions.	ANDXIC	- EN	ago,	360	pati	14						11
or to	RTIFICATION	if sny, leeding to Imme cause. Enter UNDERLY	diate					400	200						11
er t	2	CAUSE (Disease or inju		IZESF OUE TO	OR AS A CO	INSERTIENCE	050	1 RIC	251						1
Hygiene or other	Ē	thet initiated events resulting in death) LAS	т		THE		01.								VEATES
y, o	Ü		-	1. //-	>/20/										1
th and Menta any Injury,		PART il. Other significe	ont condition	s contributing to	death but	not reaultin	g in th	ne underly	ing cause	given in	Part i. 24	a. WAS AN		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
th an	EDICAL											YES 2	-		COMPLETION OF CAUSE OF DEATH?
Health a	MEC							,					2-		1 - YES 2/ NO
3 sh	10	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF	DEATH	YES [NO	□ UN	CERTAIL	N D				
m 2	¥.	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL		26.	PLACE OF O	EATH (C	heck only o	ne)						
in the State Dept. of H	PHYSICIAN	1 YES 2 NO		HOSPITAL:	ER/Outpatio	nt 3 🗆 DO/		WER: Nursing H	ome 5 🗆 F	lesidence	8 Other (S	pec/fv)			
d th		27. MANNER OF DEATH	-	28e. DATE OF (Month, D		28b.	IME OF	28c.	INJURY AT		28d. DESCR		JURY OCCU	UREO	
r death with	ВУ В		Pending Investigation	(WORKI, D	ay, rear;		INJUNT		WORK? YES 2	□ NO					
r dea	8	0 0 0 1 1 1 1	Could not be	28e. PLACE O	F INJURY — etc. (Specify)	Af home, ferr	n, street	t, fectory, o	ffice		281. LOCATIO		nd Number o	or Rural Ro	oute Number,
afte 28	ETE		determined	bulliany,	etc. (Specify)						City of I	own, State)			
hours after death with Item 28 Is marked,	ا ت	290. CERTIFIER 1 CERT	TIFYING PHYSIC	CIAN: To the best of	my knowlede	ne. death occ	ts benu	the time d	ate and plac	a and due	to the cause/	a) and man	nor es etete	4	
2 =	OMPL														end menner se stated.
TAN	O	29b. SIGNATURE AND TITLE													
be filed within 7	B	M	ANN	22	2	- na	2		296. 130	ENSE NUM	3/7		Zya, DATE	SIGNEO	(Month, Day, Year)
2 8 ≥	임	30. NAME AND ADDRESS OF	F PERSON WHO	COMPLETED CAUS	SE OF DEATH	(ITEM 27) /7	pe, Print	t)	10	-, -	-1-		. 6	> ((7 170
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6		31. DATE FILEO (Month, Day, JUN 1		Jana da	R'S SIGNATI	Carolalle									



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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME /First Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY YEAR Edward Pantaleon Joseph Marrone June 24, 1995 M 0112 4. SOCIAL SECURITY NUMBER 5. SFX 7. DATE OF BIRTH
(Month, Day, Year)
JULY 27 1907 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 578 50 6195 1 X M 2 | F 87 NewYork use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Calvert Memorial Hospital Prince Frederick Calvert 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Calvert Prince Frederick 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3539 Cassell Blvd. 20678 United States retained by the hospital or attending physician, 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuban, Mexican, Puerto Rican, atc.)

1 YES 2 MO Specify: 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married BY Specify white 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high 딥 funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL map maker Government 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Sumame) Ħ Thomas Marrone Italia Genre BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) 20678
3539 Cassell Blvd. Prince FRederick, Maryland 2 Anne Harmon hours after death. Page 6 may be e 20e. METHOD OF DISPOSITION
1 Buriel 2 Cremetion 3 Re DATE 28c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of must 1 Burlet 2 Cremetion 3 Removal from State complete, comp 22. NAME AND ADDRESS OF FACILITY RAUSCH FUNETAL HOTTE examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 4405 Broomes Is. Rd. POrt Republic Maryland20676 filled in by the the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between cremation, or IMMEDIATE CAUSE (Finel Onset and Death RATION PNEWMONIA diseese or condition resulting in desth) and completely fi burfal, cremation event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 9 If sny, issding to immediate attending physician Cause Enter UNDERLYING CAUSE (Disesse or injury other DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST 0 the atten PART II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS n signed by ti Althorn d'sien, 41.2 AMILABLE PRIOR TO COMPLETION OF CAUSE PERFORMED? 1 TYES 2 TLNO disorder, properturion OF DEATH? 1 YES 2 LNO 5 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO INCERTAIN I PHYSICIAN: 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) item certificate h EXAMINER? HOSPITAL: OTHER: 1 Dinpetient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 6 27. MANNER OF DEATH 26b. TIME OF 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, this 1 Natural 5 Pending 1 YES 2 NO After 1 BY Investigation 2 Accident 28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify) DIRECTOR: At hours after de item 28 is r 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be COMPLETED 4 Homicide determined Hem 29e. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner es stated. Ö HOSPITAL FUNERAL I 900 TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) and menner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER Of Her 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 图 435 -25 24/93 6 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5 Mukesh Mathur, M.D., Prince Frederick, Md. 20678 31, DATE FILED (Month, Day, Year) 32 REGISTRAR'S SIGNATURE JUN 26 1995



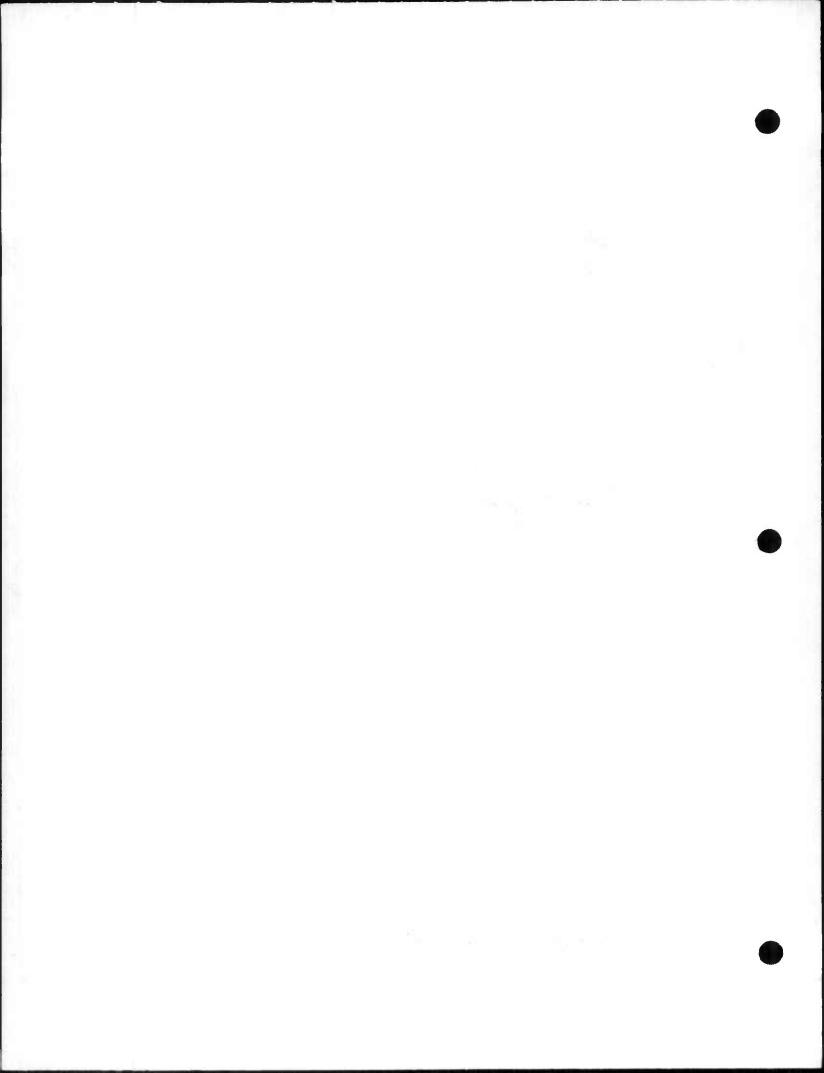
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TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law inquires that the death certificate be escorted within 28 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely flied in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be flied within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to turial, cremation, or removal.

IMPORTANT: If them 28 is marked, or flem 23 shows any injury, or other fraumatic event, the medical examiner must be notified at once.

	REGISTRAR		CERTIF	FICATE O	F DEATH	REG. NO					
	DECEDENT'S NAME (First, Middle, Lest) Pa	ul Augu	ustine	1	MORAN	2. DATE OF DEATH	3 19 9 5	3. TIME OF DEATH 9:30 A			
- 1			GE (In yrs. last birthday)			7. DATE OF BIRTH		TTHPLACE (State or Foreign			
		M 2 □ F	80 YAS.	MONTHS DAYS		Oct 2 1914		Wash DC			
-	9a. FACILITY NAME (If not institution, give street			96. CITY, TOWN	OR LOCATION OF D	EATH	9c. COUNTY OF	DEATH			
DIRECTOR	3927 Summer City	Blvd		Ches	sapeake B	each	Ca	alvert			
Ä	10e. STATE 10b. COUNTY		10c. CI	TY, TOWN OR LOC	ATION			10d. INSIDE CITY			
	MD Cal	(Chesapea		LIMITS? 1 ☐ YES 2 ☑ NO						
FUNERAL	10e. STREET AND NUMBER				Of. ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?			
N.	3927 Summer City				20732			S.A.			
	1 Never Married 2 Married	2. WAS DECEDENT EVE FORCES? 1 VI IF YES, GIVE WAR OF	R IN U.S. ARMED ES 2 NO	13. WAS DI	ECENDENT OF HISPA specify Cuban, Mexico	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)	or No — 14. R/	ACE — American Indian, ack, White, etc.			
B	3 Widowed 4 Divorced	WW II	R DATES	1 🗆 YE	white						
COMPLETED	16. DECEDENT'S EDUCAT (Specify only highest grade co	rion mpleted)	(Give kind of	USUAL OCCUPAT	TION nost of working	16b. KIND OF BU	SINESS/INDUSTRY				
Ë		College (1-4 or 5+)	life. Do NOT (ise retired.)	To the training						
NA P	17. FATHER'S NAME (First, Middle, Last)			wner				e Station			
	Paul Augustine	Moran			Louise	ME (First, Middle, Meiden	,	5.]]:			
BE	19a, INFORMANT'S NAME (Type/Print)	HOLGI	19b. MAILIN	ADDRESS (Street		Route Number, City or Tow	n State Zin Code)	Mulligan			
2	Mary E. Moran							, MD 20732			
	20a. METHOD OF DISPOSITION 1 ★ Burlel 2 □ Cremation 3 □ Remove	ol danum State	20b. PLACE AND DATE	OF DISPOSITION /	Verne of	DATE 20c LO					
	4 Donation 5 Other (Specify)		Mary Land	Land Veterans Cem 6-26-95 Cheltenham, MD							
	21. SIGNATURE OF PUNERAL SERVICE LICEN	CILITY									
	Jan L	10/		Raus	ch Funera	al Home, PA	Owing	rs, MD			
	22. PART I. Enter the Insesses, Dr cor shock, o heart feliure. Lis	nplications that caus	sed the death. Do	not enter the m	ode of dying, suc	h ss cerdisc or resp	iratory srrest,	Approximate			
1	IMMEDIATE CAUSE (Final	,						interval Between Onset and Death			
	disease or condition a.	ATI	ressel	cotru	Car	lio vascy	la Dicc	g ct			
		DUE TO (OR A	S A CONSEQUENCE C	NF):			7				
CERTIFICATION	Sequentially list conditions, b.	DUE TO (OR A	S A CONSEQUENCE O	MT:							
CA	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury										
E	that initiated events resulting in death) LAST	DUE TO (OR A	S A CONSEQUENCE C	SEQUENCE OF):							
5	resulting in death) CAST										
	PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WE										
EDICAL	Char c	Obstruc	ty Pulma	D.	(end)	PERFOR	RFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE				
WE	- Prostay	Cara	·SPI	Performed? 1 yes 2 No 1 yes 2 No 1 yes 2 No 1 yes 2 No							
	DID TOBACCO USE CONTRIE	BUTE TO CAUSE	OF DEATH Y	ES NO [UNCERTAIL	V D		7			
S I	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:	26. PLACE OF DEA)						
XS.	1 ☐ YES 2.2700	☐ Inpetient 2 ☐ ER/O	utpatient 3 🗆 DOA	OTHER: 4 - Nursing Ho	me Residence	8 Other (Specify)					
PHYSICIAN:	27. MANNER OF DEATH 1. Natural 5 Pending	26s. DATE OF INJUR (Month, Day, Year			JURY AT ORK?	28d. DESCRIBE HOW I	NJURY OCCURED				
备	2 Accident Investigation				YES 2 NO						
COMPLETED	3 Suicide 8 Could not be 4 Homicide determined	building, etc. (S	RY — At home, farm, pecify)	street, factory, off	ce	28t. LOCATION (Street a City or Town, State)	and Number or Rura	I Route Number,			
5	29a. CENTIFIER		onessa esta s								
ĕ	(Check only Certifying Physicial one) 2 Medical Examiner:					to the cause(s) and mar					
	290. SIGNATURE AND TITLE OF CERTIFIER	^/)								
BE BE	/1/1×	X	/		29c. LICENSE NUI	1	29d. DATE SIGNED (Month, Day, Near)				
٩	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF	DEATH (ITEM 27) (Type	, Print)			0				
	Jonathan Lowen	thal, MD	Prince	Frede	erick, N	1D 20678					
	31. DATE FILED (Month, Day, Year)	32. BEGISTRAR'S SU	GNATURED 1			-	-				
- 1	11 IN 9 6 1995	July Dave	MAN WANTER	1				I			



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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ZA hours after death. Page 6 may be retained by the hospital or attending physician.	4. FUNERAL DIRECTOR: Affeir this certificate has been signed by the attending physician and completely filled in by the funeral director page 5 should be detached for use as the hunauransit nermit. Pages 1 2 should	be filed within 72 hours after death with the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal.	MPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE H	TO THE FI	be filed w	IMPORT

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.

1. DECEDENT'S NAME (First, Migdile, Lest)

2. DATE OF DEATH MONTH CONTROL OF DEATH CONTROL OF DEATH MONTH CONTROL OF DEATH MONTH CONTROL OF DEATH MONTH CONTROL OF DEATH MONTH CONTROL OF DEATH MONTH CONTROL OF DEA

										116.110			
	DORIS JEAN MUUER 2. DATE OF DEATH MONTH ON 1908										OYEAR :	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 5, SEX 6, AGE (In yrs. I					fay) IF UND	ER 1 YEAR	IF UNDE	R 24 HRS.	7. DATE OF BIRTH B. BIRT			LACE (State or Foreign
1	330-38-7516 1□M2XDF 50					S. MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year)	111	Country)	
	9a. FACILITY NAME (If not in	9a. FACILITY NAME (If not institution, give street and number)					9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUR					MASO	n City, Iowa
S S	FALLSTON GENERAL HOSPITAL					Fal						larford	
5	RESIDENCE OF DEC	10b. COUNT			Trac								
DIRECTOR	MD		ford			CITY, TOWN		TION					10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	nar.	101·u			elcamp		H. ZIP COD			T		YES 2 NO
RA	4420 Patriot Garth						10	2101					IAT COUNTRY?
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN	IT EVER IN U	I.S. ARMED	13	WAS DE			IC ORIGIN? (Specify Yes	US		- American Indian.
H	1 Never Married 2 Merried FORCES? 1 YES 2 Y				2 7 NO	NO If yes, sp			n, Mexican Specify:	, Puarto Ricen, etc.)	01 110-	Black,	White, atc.
ВУ	3 Widowed 4 Dive	rced							ороску.			Specify:	White
COMPLETED	15. DEC (Specify only	EDENT'S EDU- y highest grade	CATION completed)	- 10	(Give kind	IT'S USUAL O	during me		na	16b. KIND OF BUS	SINESS/IN	DUSTRY	
٣	Elementary/Secondary (0	1-12)	College (1-4 or 5			OT use retired.	·						
ž I	17. FATHER'S NAME (First, M	Iddin Lock	2		Admini	strat	ive			Govern			
	Delmar A. M									ME (First, Middle, Malden			
H	19a. INFORMANT'S NAME (7				T 195 MAII	ING ADDRES	ee /Stmat			a M. McLee			
2	Robert M. N				RI	R#2 E	Sox 2	520	GT 6	enville, P	n, State, Zi	17320	
	20g, METHOD OF DISPOSIT	ION _		20b. PI		TE OF DISPO	_		-	OATE 20c. LO			
	1 🗓 Burial 2 □ Crematio 4 □ Donetion 5 □ Other		oval from State	cemete	ery, cremetory	or other plece	1		n 6	5/28/95 T			
	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEL			22	NAME A	NO AODRE	SS OF FAC	ILITY	LIIIO	111m, 1	МП
	Ny leu	419	de	do		G	eipl	e Fu	neral	L Home, I	nc.		
	23. PART i. Enter the di	seases, or o	complications that	t caused ti	he deeth. [o not ente	r the mo	de of dy	ing, such	Glen Rock	ratory a	17:	Approximate
	immediate cause (Fin	eert fallure.	List only one ceu	ise on eacl	h line.								interval Between Onset and Death
	disease or condition		. Ur	Usens	.5								300,15
	disease or condition resulting in death) But TO JOR AS A CONSEQUENCE OF): But TO JOR AS A CONSEQUENCE OF):									servy			
Z	Sequentially the anadisine of a Dilateral Memory 3 days									3days			
Ĕ	If any, leeding to immediate												
FIC	CAUSE (Disease or Injury Label												
CERTIFICATION	thet initiated events OUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST												
	d												
MEDICAL										VERE AUTOPSY FINDINGS			
ğ		910					1 🙀 YES 2	□ NO	C	OMPLETION OF CAUSE OF DEATH?			
- 1										_		1	☐ YES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\) NO \(\) UNCERTAIN \(\)												
i i	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 SAMINER? 1 OF DEATH (Check only one) TOTHER: 1 OF DEATH (Check only one) OTHER: 1 OF DEATH (Check only one)												
¥	27. MANNER OF DEATH	ł	28a. DATE OF			TIME OF		URY AT	T	28d. DESCRIBE HOW IF	N ILLEY OC	CLIBED	
- 10		Pending	(Month, D	ay, Year)		INJURY	WC	PRK7		ZOG. DESCRIBE HOW IF	NOON! OC	CONED	- 1
ЭВУ	Accident Investigation 3 Suicide S Could set be 28s. PLACE OF INJURY — At home, fair					m, atreet, fac				25f. LOCATION (Street a	and Numbe	r or Rural Rou	ite Number,
COMPLETED		detarmined	building,	atc. (Specify)						City or Town, State)			
٦	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.												
OM	(Check only a MEDI	CAL EXAMINE	R: On the basis of e	namination ar	nd/or investig	ation, in my	opinion, d	leath occur	red at the ti	lme, data and place, an	d due to t	ha cause(a) e	and menner sa stated.
	296. SIGHATURE AND TITLE	-4-		/					ENSE NUME				fonth, Day, Year)
BE C	(Xuo	-M	ileex					V21	833	,cg	DU	re 2	4 1995
٩	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	SE OF DEATH	I (ITEM 27)	Type, Print)	Λ		1	0000			
	LINDA	P	rceluc	+	101	C (NH	ell	wor	1/30x Cer	MI	512	1/1
	JUL 06 1	195	12 NEGISTRA	R'S SIGNATU	IRE Latt								
	0 4 m v v N	/1			-								

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHY TO THE FUNERAL DIRECTOR. After this be filed within 72 hours after death with IMPORTANT: It Item 28 is market

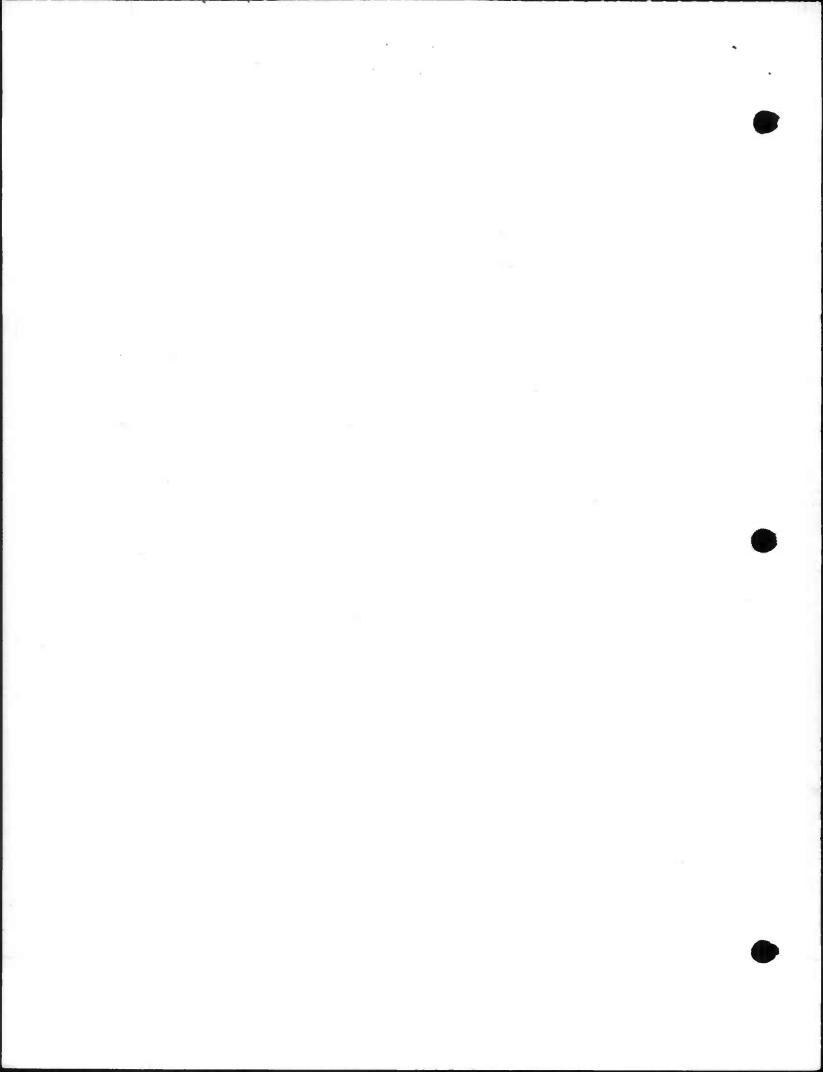
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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DALLIMOHE, MARTLAND 21213-0020	MARTLAND 21213-0020
PHYSICIAN: The law requires that the death certificate be executed within mounts after death. Page 6 may be retained by the hospital or attending physician.	e retained by the hospital or attending physician.
this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	5 Should be detached for use as the burial-transit permit, Pages 1, 2, 3 should
n with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
plant or them 23 shows and lating as other transmists are at the modified averaging the setting as and	

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.												
1. DECEDENT'S NAME (First	, Middle, Last)				-		DEATT		2, DATE OF DEATH 3, TIME OF DEATH			3. TIME OF DEATN
Patrick Wa	alter M	rockowsk	ci						MONTH DAY YEAR 6 18 95			9:40 A M
						1 YEAR	IF UNDER 24 F	rs. 7. D.				PLACE (State or Foreign
218-03-4348 1 ₺ ₩ 2 □ F 77 YRS. MON 9a. FACILITY NAME (if not institution, give street and number)						DAYS			3/12/17	l a cours		MD.
13314 Sir	-			ſ	90. GH 1,	IOWN	Ocean City sc. COUNTY OF DEATH Worcester					orcester
RESIDENCE OF DEC	CEDENT							ccarr	City		144	orcester
10a. STATE MD	10b. COUNTY	rcester		10c. CITY			C'1					10d. INSIDE CITY LIMITS?
10e. STREET AND NUMBER		i cester					ZIP CODE	<u> </u>		10a CITIZ	EN OF W	1 X YES 2 NO
13314 Sine	epuxent	t Ave.					101. ZIP CODE 109. CITIZEN OF WHAT C					
11. MARITAL STATUS		12. WAS DECEDENT	EYER IN U.S.	ARMED			ENDENT OF H	ISPANIC OR	IGIN? (Specify Yes		14. RACE	- American Indian.
1 Never Married 2 3 Widowed 4 XDivo		FORCES? 1 []NO				lexicen, Pue Specify:	rto Rican, etc.)		Speci	r, White, etc.
	EDENT'S EDUCA	WW II	Lan									white
(Specify onl	y highest grade o	College (1-4 or 5+)		Give kind of wife. Do NOT use	ork done r	UAL OCCUPATION to do working stired.) 16b. KIND OF BUSINESS/INOUSTRY to do no during most of working stired.)						
12				Buy	er				Paper	Produ	ıcts	
17. FATHER'S NAME (First, M									st, Middle, Maiden	Sumame)		
Walter S.		<u>wski</u>						en Ko				
194. INFORMANT'S NAME (1		ale:	1						lumber, City or Tow		,	
Douglas M		SKI	1000000						elair, M			
1 段 Buriel 2 ☐ Cremetic 4 ☐ Donation 5 ☐ Other	on 3 🗆 Remov	mi from State	cemetery, o	rematory or oth	rer place)	ITION (Na	me of	010	6/21/9	CATION — C	ity or To	wn, State
21. SIGNATURE OF PUNERA	_	NSEE	I wat y	lallu	22.1	NAME AN	D ADDRESS O	eter y	6/K1/A	2 Ber	iian	, MD
1/1/3	tor	3										al Home
22 DADT I Enter the	us/o	Mitage	annered the		1	08 1	<u>William</u>	s St.	Berlin	, MD	21	
23. PART I. Enter the d ehock, or h	esrt fsilure. LI	at only one cous	e on eech lii	ne.					ardiac or reapi	ratory arre	et,	Approximate Interval Between
IMMEDIATE CAUSE (Fir disease or condition resulting in death)	nai → a.		Pa	etstro	5	ai	need					Onset and Death
		DUE TO (C	OR AS A CONS	EQUENCE OF):							
Sequentielly ilst conditi		DUE TO (C	OR AS A CONS	EQUENCE OF								
if any, leading to imme- cause. Enter UNDERLY		502.10 (0	A CONS	ECCENCE OF	,.							
CAUSE (Disease or Inju thet initieted events	iry a	DUE TO (C	OR AS A CONS	EOUENCE OF):							
resulting in desth) LAS	T d.											
PART II. Other significe	ent conditione	contributing to d	eath but not	regultine in	the un	el a visal ma	acusa sha	a la Dani l	T		1	
Air a. Other agrinos	- Conditione	continuum to a	eath but not	resulting ii	i the un	deriying	csuse give	n in Part i	. 24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
									1 - YES 2	O-NO		OF DEATH?
DID TOBACCO U	SE CONTRI	BLITE TO CALL	ISE OF DE	ATLI VE		10 🗆	LINCER	TAINL D				1 TES 2 NO
25. WAS CASE REFERRED TO		BUTE TO CAU		ACE OF DEATH			UNCER	IAIN L				
EXAMINER?		HOSPITAL:			OTHER	1:	5 Teside	nne s 🗆 f	Wher (Specify)			
27. MANNER OF DEATN		28a. DATE OF IN	JURY	28b. TIME	OF T	2Sc. INJU	JRY AT		OESCRIBE NOW I	NJURY OCCL	IRED	
	Pending investigation	(Month, Day,	, roar)	INJU	М	1 🗌 Y	ES 2 NO	0				
2 Accident investigation 3 Suicide 8 Could not be determined determined determined and control of the determined determin									loute Number,			
29e, CERTIFIER				V2 2 2 2 2	-000							
(Check only		AN: To the best of m On the basis of exa) and manner as stated,
29b. SIGNATURE AND TITLE						Т	29c. LICENSE					(Month, Day, Year)
Stera	-Wast	ens U	an				-	797	3			-95
30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUSE	OF OEATN (IT	EM 27) (Type, 1		Ct:	Ro	1.0	۱ . ما ۱	101)	
31. DATE FILED (Month, Day,		32. REGISTRAR	S SIGNATURE	20	uy	31:	Jer	1117	, ma	+181	/	
JUN 21	1995	Julia Den	in the	Ass.								

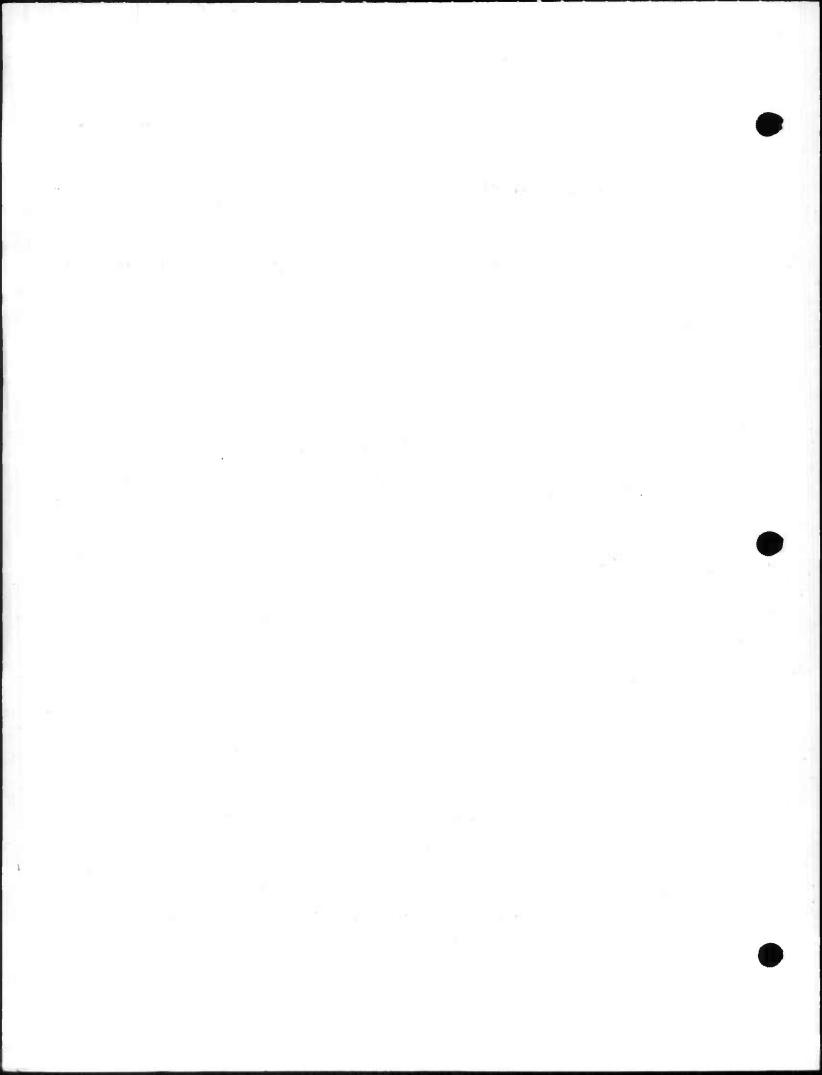


0/2

2, 3 should

BALTIMORE, MARYLAND 21215-0020	24 hours after death. Page 6 may be retained by the hospital or attending physician.	filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, ion, or removal.	the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within A hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

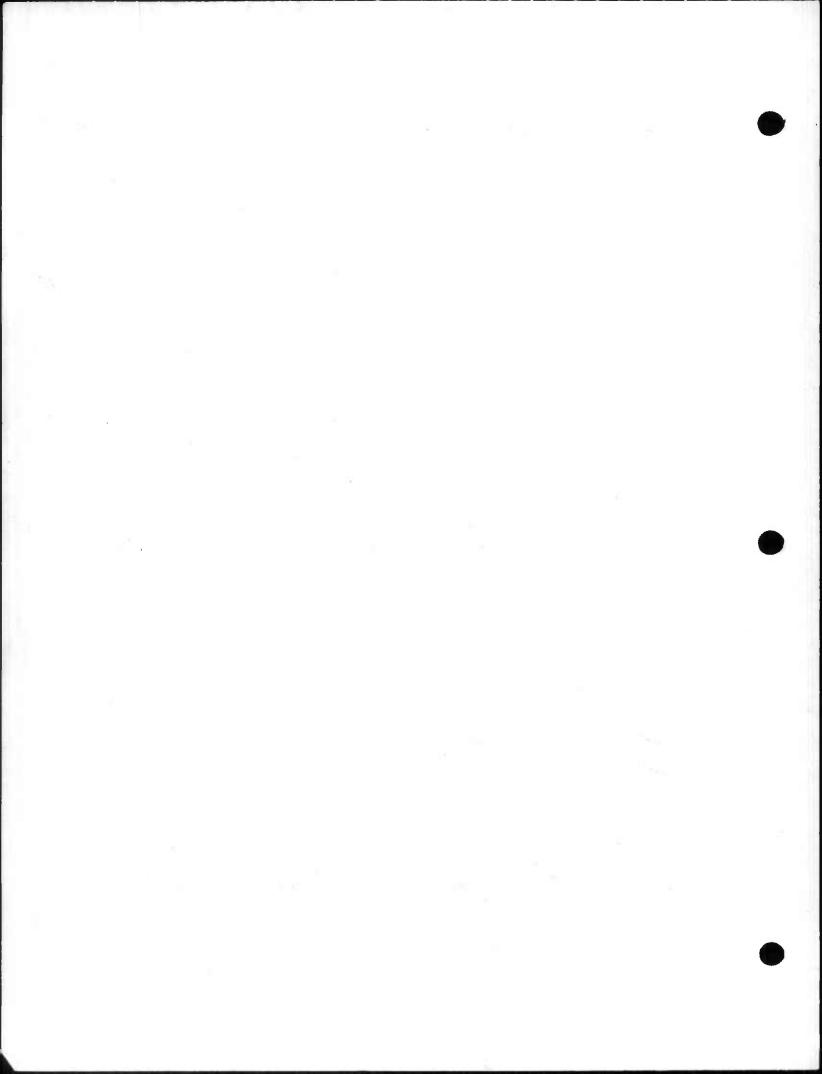
	ITEMS: 23	PART I,	, II, 27, I	PER MEO F	ILM G-	725 7	/21/9	5 t.t				95	2	16/9	
	1 - FOR STATE REGISTRAR		STATE OF I		/ DEPAI					MENTA	L HYGIEN	E			
	1. DECEDENT'S NAME (First TAMESHA	, Middle, Last)	М.			MII	NOR			2. DATE MONTE		199	YEAR 95	3. TIME OF DEATH 7:58 Pm	
	4. SOCIAL SECURITY NUMBER 066-62-9842		5. SEX 1	6. AGE (In yrs			DAYS	IF UNDER	24 HRS. MIN.	(Monti	OF BIRTH h, Day, Year) 25, 1	972	Country)	YORK	
OR	9e. FACILITY NAME (If not institution, give street end number) 3208 CURTIS DRIVE #112							OW H				9c. COU	NTY OF DEA	GEORGES	
ECT	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY					TY, TOWN	OR LOCA	TION						104 INCIDE CITY	
DIRECTOR	NA	NA						D.C	•	1			10d. INSIDE CITY LIMITS? 1 XYES 2 NO		
FUNERAL	10e. STREET AND NUMBER		2 - "2				10	, ZIP CODE						HAT COUNTRY?	
NE	118 Wayne	Place,	S.E. #3	T 5255 111 11 4	4.0000	- L.,			032					tates	
ВУ	1 Never Merried 2 3 Widowed 4 Divo		FORCES? 1	YES 2 K	NO	If yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 YES 2 NO Specify:						e or No 14. RACE — American Indian, Black, White, etc. Specify: BLACK			
臣	15. DEC (Specify onl	EDENT'S EDUC y highest grade	CATION completed)		DECEDENT'S	work done	during me	ON ost of workin	g	16b	KIND OF BUS	INESS/IND	USTRY		
COMPLETED	Elementary/8econdary (0-12) College (1-4 or 5+) HOM					ie. Do NOT use retired.) ME MAKER					RIVATE		Ε		
BE CO	GEORGE T.		SR.					1117.5-	RTHA		Middle, Meiden TTLE	Surneme)			
10	190. INFORMANT'S NAME (7		/2/07/								ber, City or Town				
	MARTHA BATTLE (MOTHER) 57 Galveston Street, S.W. #202 Wash.,D.C. 200														
	20e_METHOD OF DISPOSIT 1 ABuriel 2 Crematic 4 Donation 5 Other	n 3 🗆 Remo	oval from State	cametary o	E AND DATE prematory or a ONY M	other place)				6/		LANDOVER, MARYLAND			
	21. SIGNATURE OF ENVERA		prise)	THANN	IONI P	22.	NAME A	NO ADDRES	S OF FAC	YTUE					
-8	» (lles	8 6	wee)	b.	M85	u i					E FUNE			,Md 20747	
CATION	IMMEDIATE CAUSE (Fir disease or condition resulting in death) Sequentially list condit if any, leading to imme- ceuse. Enter UNDERLY!	dona, diate	HEMOPER DUE TO PLACENT	ise on eech li	BEOUENCE C	or): 1 UTER				see cerd	flac or reapi	ratory err	est,	Approximate interval Between Onset end Death	
CERTIFICATION	CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST														
PHYSICIAN: MEDICAL (PART II. Other algoritica PREGNANCY	,									24a. WAS AN PERFOR 1 YES 2	MED?	1 6	WERE AUTOPSY FINDINGS WARLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES: 2 NO	
AN	DID TOBACCO U		RIBUTE TO CA		ATH Y			UNC	ERTAIN						
SICI	EXAMINER?	MEDIOLE	HOSPITAL:			OTHE	R:	5 El-Ba	aldonas (- 10				
H	27. MANNER OF DEATH		28e. DATE OF (Month, D	INJURY	28b. TIR	AE OF	28c. INJ		sidence a	28d. DES	CRIBE HOW IF	JURY OCC	URED		
ВУР		Pending Investigation	(Month, D	ay, rear)	IN	JURY M	1 🔲	PRK? YES 2 _	ND					_	
	2 Accident 3 Suicide 8 Could not be determined 25e. PLACE OF INJURY — At hor building, etc. (Specify)					street, fect	tory, offic	•			ATION (Street e or Town, Stete)	IDN (Street end Number or Rural Route Number, Town, State)			
COMPLETED			CIAN: To the best of											and menner se stated.	
BE C	296. SIGNATURE AND TITLE		, 11	-					NSE NUM					Month, Day, Year)	
TO B	T head	are d	1. Ku	/ m	A			0.0	.M.	Ε.	1	▶JU	NE 1	18,1995	
	30. NAME AND ADDRESS OF	REF	1. KIN	6- 11	1 Per		tre	et,	Bal	time	ore,	Mary	land	21201	
	31. DATE FILED (Month, Day, JUN 21 1995	,	32. REGISTRA	R'S SIGNATURE											
	JOIL WT 1222	Jun	- In surrect												



BALLIMORE, MARYLAND 21215-0020	NSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
CITIZION OF VITAL NECONDS, F.O. BOX 88/80	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24	TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

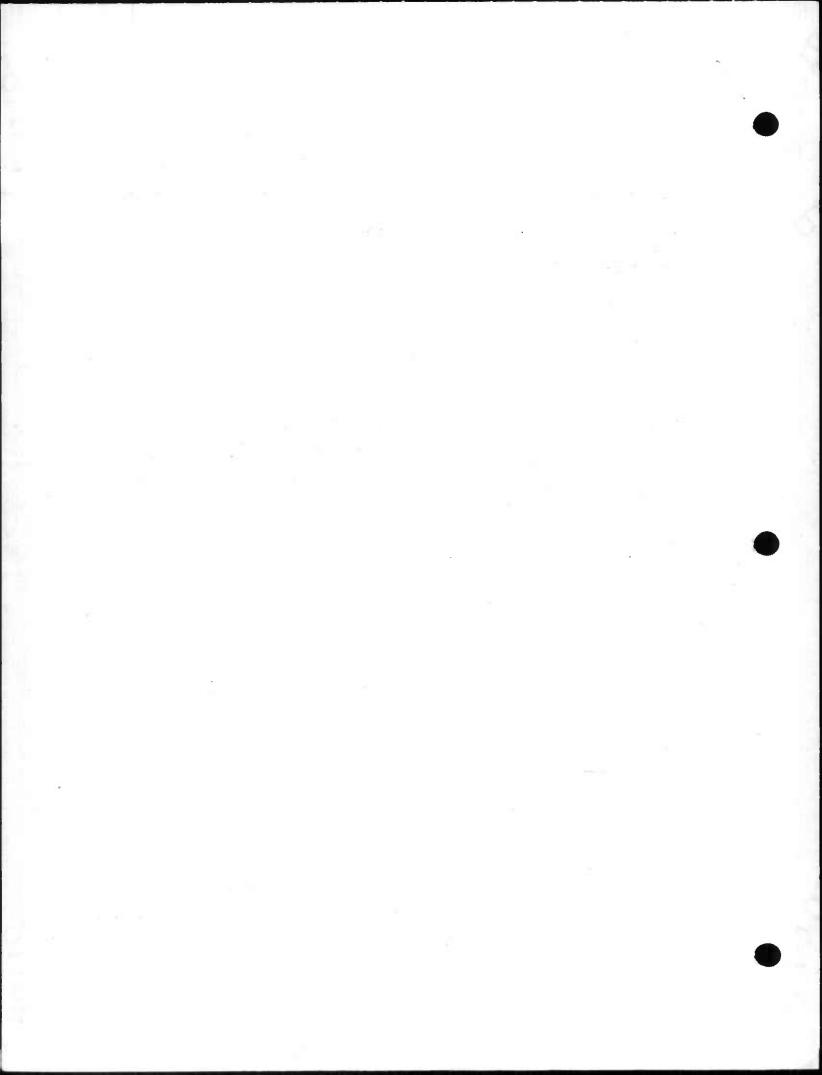
DIVISION OF VITAL RECORDS, P.O. BOX 68760

	_	FOR STATE REGISTRAR	STATE OF MARY	LAND /	DEPARTI	MENT OF H	EALTH AND DEATH	MENTAL HYGIEN			
		1. DECEOENT'S NAME (First, Middle, Last)	Medr	anc	7			2. DATE OF OEATH WONTH	9,199	3. TIME OF DEATH	
		4. SOCIAL SECURITY NUMBER 215-78-1792	URITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) $1 \square$ M $2 \sqrt{2}$ F 51 YRS. MONTHS DAYS HOURS MIN. March 17.						C	IRTHPLACE (State or Foreign ountry) nama	
		8e. FACILITY NAME (If not institution, give s	treet and number)		9	L CITY, TOWN O	R LOCATION OF D		9c. COUNTY C		
DIRECTOR		Prince George's Hospital Center					rly	Prince	ince George's		
1 2		10e. STATE 10b. COUNTY				OWN OR LOCATI			10d. INSIDE CITY LIMITS?		
		Maryland Prince George's				Raini	ZIP CODE		1 YES 2 NO		
ER		4117 31st Street				101.	20712			1 States	
FUNERAL		11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. AR	MED	13. WAS OEC	NDENT OF HISPA	NIC ORIGIN? (Specify Ve	e or No 14. F	ACE — American Indian	
BYF	- 11	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 TYES		10	1 X YES	cify Cuben, Mexic 2 □ NO Speci 1amanian			Black, White, etc.	
		15. OECEDENT'S EOU (Specify only highest grade	CATION	16a. OE	CEDENT'S US	UAL OCCUPATIO	N		Whi	(
		Elementary/Secondary (0-12)	College (1-4 or 5+)	(GI	ve kind of work Do NOT use n	done during mos stired.)	t of working				
OMPL.		12		Adm	inist	cative .	Assistar	nt Citizer	nship		
5 3	- 18	17. FATHER'S NAME (First, Middle, Last)					_	AME (First, Middle, Maiden	Surname)		
B B	ı	Maria-Angel Valle	ejos	1 401			_	Gonzalez			
2		Juan A. Medrano						Route Number, City or Tow		,	
2	ı	20e. METHOO OF DISPOSITION	20'			ST STY		nt Rainier	CATION - City o		
SPE		1 Suriat 2 Cremetton 3 Remet 4 Donetton 5 Other (Specify)	ovat from State COI	metery, cres	matory or other			23/95 Bre	-		
examiner must be notified at once. TO BE COM		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE / //	1		22. NAME AN	D ADORESS OF FA	ACILITY			
exa	Ĭ.	1 Marka	Julle	4		4		Funeral Ho		d, MD 20722	
medical	1	23. PART I. Enter the diseases, or o	omplications that cause	d the de	ath. Do not	enter the mod	le of dying, aud	ch as cardiac or resp	iratory arrest,	Approximata	
		IMMEDIATE CAUSE (Final	List only one ceuse on e							Interval Between Onset and Death	
, ie											
event,	ı	resulting in death) Habethe Cartesia 3 elevates Cardia penul from cular our tro (or as a consequence of):									
CERTIFICATION		Sequentially list conditions, if any, leading to immediata DUE TO (OR AS A CONSEQUENCE OF):									
S		Cause. Enter UNDERLYING CAUSE (Disease or Injury									
		that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEO	UENCE OF):						
CE S	1	d									
A 를		PART II. Other algnificent condition	s contributing to death i	but not re	suiting in t	he underlying	ceuse given in	Pert I. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS	
EDIC EDIC		Arthulis						1 □ YES 2		COMPLETION DF CAUSE DF DEATH?	
snows any								_		1 YES 2 NO	
AN S		DID TOBACCO USE CONTE	RIBUTE TO CAUSE C				UNCERTAI	NE			
PHYSICIAN: M		EXAMINENT?	HOSPITAL:		0	Check only one) THER:	La backet	Date of the second			
H H	ı	27. MANNER OF DEATH	1 ☐ Inpatient 2 ☐ ER/Out	patient 3	28b. TIME O	F 28c, INJU		8 Other (Specify) 28d. DESCRIBE HOW I	NJURY OCCURE	,	
marked, BY PI		1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)		INJURY	WOR	K? ES 2 NO	Edd. DEGGMDE HOW	MOONI OCCORE		
E C		3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURN building, etc. (Spe	Y — At hor	ne, farm, stree	t, factory, office		28f. LOCATION (Street City or Town, State)		ral Route Number,	
	ŀ		CIAN: To the best of my know	uladas des	th comment of	A Abra Maria diana					
BE COMPLE			R: On the beele of exemination							se(e) end manner as stated.	
BEC	I	29b. SIGNATURE AND TITLE OF CENTIFIER	7.5	Y		T,	29c. LICENSE NUI	MBER	29d DATE SIGN	NEO (Month, Day, Year)	
TO B	4	36. WAMP IND ADDRESS OF PERIODS WHO	O COMPLISTED CAUSE OF OR	M/	127) /Sun- D-	.,	12123	30	rune.	29/995	
	L	ALLEUS TO P. P. P. S. 31. DATE FILEO (Month, Day, Vose)	M REGISTRAN'S SIGN	MY	500	09 K	Ey Fur	nCf.Cp	Syn. 7	M) 2074	
			ha d'auchen Kard			,		/	V		



ITEMS: 23 PART I, 27, PER MEO FILM G-725 7/21/95 t.t

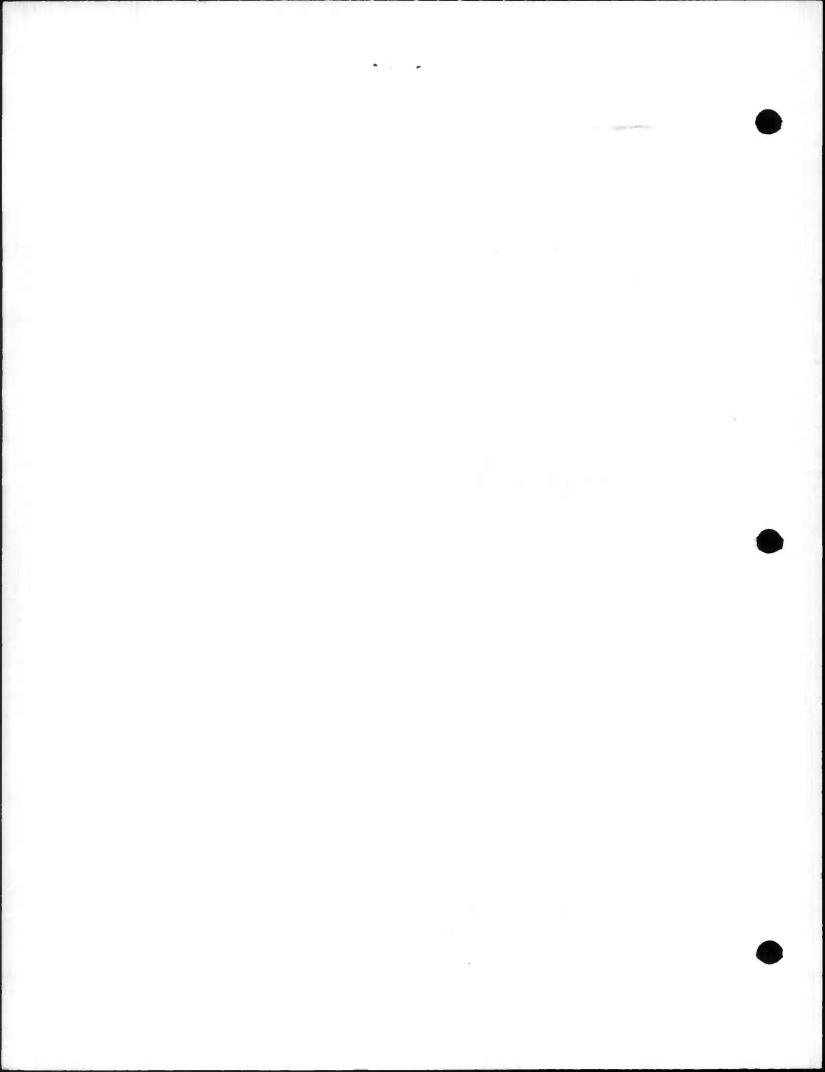
		1 - STATE REGISTRAR	ST	ATE OF N	MARYL	AND / I	DEPAR	TMENT	OF H	DEAT	AND I	MENTA	AL HYGIEN				
_ `		1. DECEDENT'S NAME (First, Middle,	Last)										E OF DEATH		3.	TIME OF OEATH	_
		Norman	Le	e		M	cCu	llou	ıah			Jui			EAR 95	2331	м
1/5		4. SOCIAL SECURITY NUMBER	5. SE			(In yrs. last	birthday)	IF UNDER		IF UNDER	24 HRS.		E OF BIRTH oth, Day, Year)	8.	BIRTHPL Country)	ACE (State or Foreign	
Pio		577-96-0635		M 2 F	3	2	YRS.			0.00			30,19	-	ARYI		
3 should	œ	9a. FACILITY NAME (If not institution,								OR LOCATIO		EATH		9c. COUNTY	OF OEA	TH	
1, 2,	16	Washington A		ist I	Hosi	pita				ia P	ark			Mon	gor	ery	_
Pages	DIRECTO		OUNTY	GEORGES CAPITOL HEIGHTS						-		10	d. INSIDE CITY LIMITS?				
permit.		MARYLAND PR	INCE G	EURGE	<u> </u>		CAP	TTOL	-	GHTS	F			- OFFISE		YES 2 NO	_
-ist	ERA	1004 BOOKER DRI	VE							2074:		10g. CITIZEN OF UNITED					
020 physician. burial-transit	FUNERAL	11. MARITAL STATUS	12. W	WAS OECEDEN ORCES? 1	T EVER I	N U.S. ARM	ED	13.	WAS DEC	ENDENT C	F HISPAN	IIC ORIG	IN? (Specify Ye		. RACE —	American Indian.	
21215-0020 Il or attending physician. for use as the burial-trar	BY F	1 Never Merried 2 Merried 3 Widowed 4 Divorced	JF.	if yes, give war or dates 1982–1983			,			ecify Cube			Rican, atc.)		Specify:	fhita, atc.	
15- tendir		15. OECEDENT'			903	16a, OEC	EDENT'S	USUAL O	CCLIPATIO	ON.	_	16	b. KIND OF BU	SINESS/INDI IS	BLAC	K	_
2 8 2	ETED	(Specify only highest Elementary/Secondary (0-12)	t grade comple		+)	(Givi	e kind of a	work done	during mo	st of working	ng	1."	B. KIND OF BO	SINESS/INDUS	INT		
	COMPL	12		A21 1 11 11	,	DESK	ANA	ALYS	Γ			C	COMPUTE	R SPEC	, IN	ic.	
LAN the hose e detach		17. FATHER'S NAME (First, Middle, La								-	Middle, Malden	Sumame)					
MARYLAND retained by the hospit 5 should be detached motified at once.	BE	NORMAN LEE MCCU 19a. INFORMANT'S NAME (Type/Print		H, SR.	•	100	MAHING	ADDRESS	. (0		ROTH						_
	2	SHARON MCCULLOU												vn, State, Zip Code)			
ALTIMORE, I leath. Page 6 may be funeral director, page 4 xaminer must be re-		SHARON MCCULLOUGH 1500 LINCOLN CIRCLE #102, MCLEAN, VA 22 20e, METHOD OF DISPOSITION 1 & Burtel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Campetery, Cremetery, Cremetery, Cremetery, Cremetery, Cremetery, Cremetery, Cremetery, Cremetery, Cremeters,															
IMOR Page 6 ma Il director, p		4 Donation 5 Other (Specify		om State	_ Gan	ARMON	Y M	ther place) EMOR	[AL	PARK		6/	9 LAN	DOVER,	MAR	YLAND	
BALTIMORE, or death. Page 6 may be the funeral director, page val.		21. SIGNATURE OF FUNERAL SERVI	CE LICEMBER	0				1		A NOFI			E FUNE	מז שח	MEC		
. 97		My D	Typ	187			M859	9	5538	MARI	LBOR	O PI	KE, F	ORSTVI	LLE,	MD 20747	
ST LE LE		23. PART I. Enter the diseases shock, or heart fail	i, or cómpli ilure. Liat o	icationa tha niy one cau	it cause use on e	d tha dea ach iine.	th. Do r	not enter	tha mo	de of dyi	ing, suci	h as cei	rdiac or reap	iratory arrea	t,	Approximate interval Between	en
F 9 F		iMMEDIATE CAUSE (Finel disease or condition		SEIZUR	E DIS	SUDDED										Onset and De	ath
ted with ted completely fille ial, cremation, event, the	1 1	resulting in death)	a			A CONSEOL	JENCE O	F):									
: 6876C solucited will and comple burial, cre natic ever	Z	Sequentially list conditions, b.															
De es cian sior to	CERTIFICATION	Sequentially flat conditions, if any, leading to immediate cause. Enter UNDERLYING															
De phy	임	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):											_				
beath certification attending printal Hygien y, or other	FH	reaulting in deeth) LAST															
0 9 4 × 3	2	PART II. Other significent con	ditions con	tributing to	deeth b	out not re	nulting	in the un	deriving	cause o	iven in	Part I.	24s. WAS AN	ALITOPSY	24h W	RE AUTOPSY FINDING	GS.
A sa da sa	ICAL												PERFO	RMED?	AV	AILABLE PRIOR TO IMPLETION OF CAUSE	
w requires the been signed pt. of Health 3 shows and	MEDI												1 YES 2	I NO	1 1	YES 2 NO	
AL RI e law red has beer Dept. of	1 1	DID TOBACCO USE CO	ONTRIBUT	TE TO CA	USE C	F DEAT	H YE	S 🗆 I	NO X	UNC	ERTAIN	4 🗆			/	*	
OF VITAL HYSICIAN: The law his certificate has with the State Depr ked, or Item 23	PHYSICIAN	25. WAS CASE REFERRED TO MEDIC EXAMINER?	1100	SPITAL: .		26. PLACE		OTHER									
F VIT. SICIAN: The certificate the State I, or Item	14S	1X YES 2 NO		Inpetient 2 2		patient 3	DOA 28b. TIM	4 🗆 Nun			sidenca		er (Specify)				_
		1 (X)Natural 5 Panding		(Month, D	Pay, Year)			URY M	WO	RK?	NO	288. OE	SCRIBE HOW I	NJURY OCCUP	RED		
NOING F I. After r death	D BY	2 Accident Investige 3 Suicide 8 Could n		28e. PLACE O	F INJURY	/ — A1 hom	e, larm, s	street, fact				261. LO	CATION (Street	and Number or	Rural Rout	e Number,	\dashv
DIVISION OF VITA DR ATTENDING PHYSICIAN: The DIRECTOR. After this certificate h hours after death with the State of them 28 is marked, or them	ETED	4 Homicide detarmin	ied		ator Jopes			-				CII)	y or Town, State)				
7 72 -	릴												suse(s) and ma				
TO THE HOSPITAL TO THE FUNERAL IS be filed within 72 h	COMPL	2 MEDICAL EX	AMINER: On t	the basis of a	xaminatio	n and/or Im	vestigatio	n, in my o	pinion, d	eath occur	ed at the	time, det	te and place, an	d due to the c	ause(s) ar	nd manner as stated.	
THE H THE FI Sed w	BE (29b. SIGNATURE AND TITLE OF CER	ITIFIER	100	4					29c. LICE	NSE NUM	IBER		29d. DATE S	IGNED (M	onth, Day, Year)	
2 2 3 3	5	30. NAME AND ADDRESS OF PERSO	ON WHO COM	PI ETED CALL	SE DE CE	ATH OTEM	27) /5	Quint'		0.	C.M	E.		Jun	e 0	6 1995	_
		DR. DENNIS	()	JTE, MD					C+~	00±	D-	.1 + -	mo	Wass	.1 ~-	2 21201	
		31. DATE FILED (Month, Day, Year)	1 3	32. REGISTRA	R'S SIGN	IATURE	PE	21111	otr	eet	Be	IT T 1	unore,	mary	Tan	d 21201	_
		JUN UO 1995	Julia	Paudio	-har	all											



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760 1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1												
	1. DECEDENT'S NAME (First, Middle, Li							2. DATE OF MONTH	DEATH	Y	YEAR	3. TIME OF DEAT
j		Everett			itchel	1		June	25 1	995		7.20
- 1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last		F UNDER 1 YEAR	IF UNDER 2		7. DATE OF (Month, D	BIRTH		8. BIRTHI	PLACE (State or For
	719-01-2834	1 🔀 M 2 🗌 F	80	YRS.	MONTHS DAYS HOURS MIN.			Sept.	7. 19	914		Jersey
	9a. FACILITY NAME (If not institution, gi	9a. FACILITY NAME (if not institution, give street and number)		96	b. CITY, TOWN	OR LOCATION			,		TY OF DE	
CTOR	Physicians Men	norial Host	oital	T	Laplata					Ch		
5	RESIDENCE OF DECEDENT				- upiace	1				CII	arles	5
	10a. STATE 10b. COU	JNTY		10c. CITY, To	OWN OR LOCA	TION						10d. INSIDE CITY
DIRE	Maryland Ch	arles	7		Nanj	emoy					ļ	LIMITS?
AL	10e. STREET AND NUMBER		10	H. ZIP CODE				10g. CITI		HAT COUNTRY?		
EB	Rt. 1 Box 85					206	662			SA		
UNERAL	11. MARITAL STATUS	T EVER IN U.S. ARM	MED	13. WAS DE	CENDENT OF	HISPANIC	C ORIGIN?	Coerify Yes	or No	14 DACE	- American India	
LL.	1 Never Married 2 Married	FORCES? 1 IF YES, GIVE W	YES 2 NO	0	If yes, s	pecify Cuban,	Maxican,	, Puarto Rica	n, etc.)	- 110	Black,	, White, etc.
B	3 Widowed 4 Divorced	AN OH DATES		1 L YES	S 2 NO	Specify:				Whi		
	15. DECEDENT'S E	16a, DEC	EDENT'S USU	UAL OCCUPATI	ION		165 KI	ND OF BUS	INESS/IND		LE	
	(Specify only highest gr Elementary/Secondary (0-12)		(Giv	e kind of work Do NOT use re	done during m	ost of working		100, 10	01 203	NESS/IND	OSINI	
2		College (1-4 or 5+	'	Supervisor					Mora	1 Co	(70m)	mont
COMPL	17. FATHER'S NAME (First, Middle, Last)			per vis							ileit	
- 1		George Washington Mitchell					18. MOTHER'S NAME (First, Middle, Meiden Surname)					
8	19a. INFORMANT'S NAME (Type/Print)	on Miller.	-	Lena Katherine Penner Ling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
2	The state of the s										Code)	
	Mary L. Mitchel	<u> </u>		Rt. I	Box 8	b, Nar	ı jem	oy, M	206	62		
	20a. METHOD OF DISPOSITION 1.X. Burial 2 Cremation 3 R	lemoval from Stata	ND DATE OF D	1 Box 85, Nanjemoy, MD 20662 EOFDISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Other place)								
	4 Donation 5 Other (Specify)	2	6-28 Falls Church, VA									
ı	21. SIGNATURE OF FUNETIAL SERVICE	LICENSEE	**			ND ADDRESS						
	Huntt Funeral Home Benjamin M. Matthews M00658 P. O. box 156, Waldorf, MD 20604-											
\dashv	Benjamin M. Matthews M00658 P. O. box 156, Waldorf, MD 20604-0156 23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately and the course of the course											
	snock, or haert fallu	re. List only ona caus	se on each line.							atory arre	eat,	Approxima Interval Be
	IMMEDIATE CAUSE (Final disease or condition	1-	4 1/2		- n.	,						Onset and
		. a allow	le upp	el 6	1 /2/1	Id.						1 < 1 /
	resulting in death)				- 700	Park.						
	resulting in death)	DUE TO	(OR AS A CONSEQU	UENCE OF):	- 1	0 1	10.					
NO		DUE TO	ior as a consequ ntritus	LESC	phas	cal l	lar	ices				unk
ATION	Sequentially list conditions, if any, leading to immediate	b. OUE TO (OR AS A CONSEQUENCE OF AS	VENCE OF):	phag	cal l	lar	ices				unk
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR

#14 6/22/95 ELM P.G.C.
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

95

	REGISTRAR		C	ERTIF	ICATE OF	DEATH	F	EG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF	DEATH	-		3. TIME OF DEATH	
	JOSEPH	М.		NIX	•		JUNE	17		YEAR	13:28 F) M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. le		IF UNDER 1 YEAR	IF UNDER 24 HRS.	T DATE OF	DARWY LA	, 100		HPLACE (State or Foreign	
	215-82-7134	1 G M 2 G F	29	YRS.	MONTHS DAYS	HOURE MIN.	(Month, Da	y. Year)		Count	aryland	
l oc	CUDURDAY											
ΙĒ	SUBURBAN HOSPITAL Eethesda MONTGOMERY											7
DIRECTOR	10a. STATE 10b. COUNT	Y		10c CIT	Y, TOWN OR LOCA	TION					10d, INSIDE CITY	
<u>=</u>	DC N	I/A		J							LIMITS?	
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A A					10	I. ZIP CODE			10g. CIT		WHAT COUNTRY?	
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FUNERAL	11. MARITAL STATUS 1 Never Married 2 A Married	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. AF			ENDENT OF HISPAI			or No-	14. RAC	E — American Indian, k, White, sie	
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	45 0505051170 504	1	Last 144								District.	
H	15. DECEDENT'S EDU (Specify only highest grade	completed)	(6	live kind of	USUAL OCCUPATION WORK done during mo		16b. KIN	D OF BUS	SINESS/INC	DUSTRY		
2	Elementary/Secondary (0-12)	College (1-4 or 5	+)	Do NOT u								
E	12 Yrs	None	C	able	Tech				ronic	cs		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA			Surname)			
BE	James Joseph	n Nix					mily B					
2	19e. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (Street	and Number or Rural	Route Number, C	ilty or Town	. State, Zip	Code)		
-	Susan Nix			Same	as 10a	,b,c,d,e	,&f					
	20e. METHOO OF DISPOSITION 1 X Buriel 2 Cremetion 3 Rem	ound from Ctut.	20b. PLACE	ANDDATE	OF DISPOSITION (Ne	eme of	DATE	20c. LO	CATION —	City or To	own, State	
	4 Donation 5 Other (Specify)	Count from State	Ft Li	ncoli	ther place) 1 Cemete:	ry 6/2	21/95	Br	entwo	ood,	Md.	
	21. SIGNATURE CONTINENAL SERVICE LIC	CENSEE	1			ND ADDRESS OF FA	CILITY				-	
	- (///max)	V \2004	, , 11	1			n T. Ri			-		
13	3030 12th St NE, DC 20017 23. PART I. Enfer the diseases, or complications that caused the death. Do not enter the mode of dying, such ea cardiec or reepiratory arrest, Approximate											
	shock, or heart failure.	List only one cau	t caused the de ise on each line	eath. Do i e.	ot enter the mo	de of dying, suc	h ea cardiec	or reepi	ratory an	rest,	Approximate Interval Between	
	IMMEDIATE CAUSE (Final		0 ' '	,							Onset and Da	
	disease or condition resulting in death)	. Hea	OR AS A CONSE	uri	es							
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Z	Sequentielly list conditions,	b										
Ĕ	if any, leading to immediate	DUE TO	(OR AS A CONSE	OUENCE O	-):							
2	CAUSE (Disease or Injury	с										
H	thet initiated events resulting in death) LAST	DUE TO	(OR AS A CONSE	OUENCE O	ጉ :							
CERTIFICATION	Teaching in death) CAST	d										
0	PART II. Other aignificant condition	a contributing to	death but not i	resulting	n the underlying	a cause given in	Part i 24	. WAS AN	ALITODOV	1 245	. WERE AUTOPSY FINDIN	100
DICAL	-3		death but not i	resulting	in the underlying	g cause given in	Part 1. 244	PERFOR		240	AWAILABLE PRIOR TO	
	-						1 0	YES 2	□ NO		COMPLETION OF CAUS OF DEATH?	12
≥											1 💓 YES 2 🗌 NO	. 1
PHYSICIAN:	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEA	ATH YE	S NO	UNCERTAIL	И□					
3	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	CE OF DEA	OTHER:							
S	1 X YES 2 □ NO	1 Inpatient 2	ER/Outpatient 3	□ DOA		e 5 🗌 Residence						
H	27. MANNER OF DEATH	28s. DATE OF (Month, D	INJURY ay, Year)	28b. TIM	E OF 28c. INJ	URY AT	28d. DEŞCRII	BE HOW II	JURY OC	CURED	RIVER,	
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"	29e. CERTIFIER	CIAN: To the heat of					V	-			Co. 1110	\dashv
COMPLETED	2 W. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) end manner as stated. (Check only one) 2 W MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) end menner as stated.											
8				vestigetic	n, at my opinion, d	wain occured at the	unne, date end	piece, an	aue to th	ie ceuse(s	s) end menner es stated	a.
BE	296. SIGNATURE AND TITLE OF CERTIFIE	1.	140			29c. LICENSE NUM	MBER		29d. DAT	E SIGNEC	(Month, Day, Year)	
0	Monald How	Mynt	עוו			OCI	ME		•	JUNI	E 18,199	5
	30. NAME AND ADDRESS OF PERSON WH											
	DONALO G, WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201											
	DOTOTICO 9, WK.	-1-								4	TO LIZOT	
	31. DATE FILED (Morith, Day, Year) IIIN 2. () 1995		RESIGNATURE							4	IG ZIZOI	

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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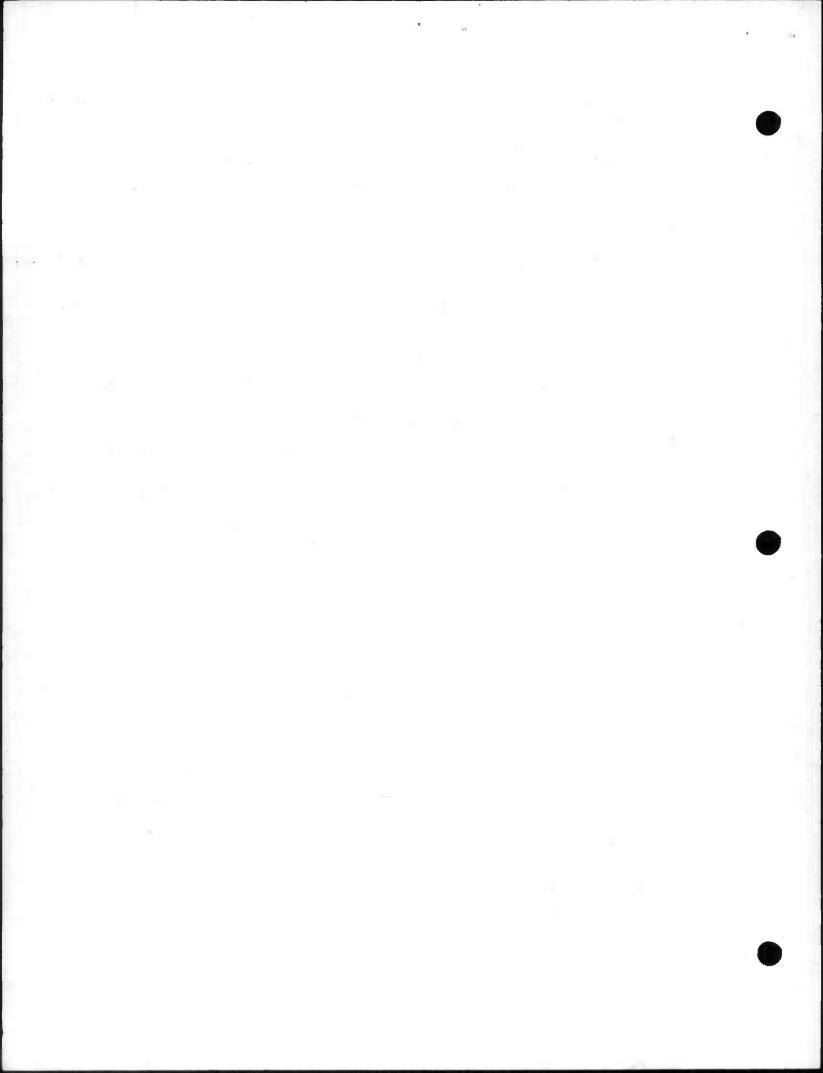
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	FOR STATE REGISTRAR		STATE OF N	MARYLAND C	/ DEPAR	RTMEN	T OF H	EALTH DEAT	AND I	MENTAL	HYGIEN!	E		
	1. DECEDENT'S NAME (First							1		2. DATE O				3. TIME OF DEATH
	ROBE	RT	RAYM	OND	0	LS	10	1		JUNE	_ 5	199	YEAR	~ 7PM M
	4. SOCIAL SECURITY NUM		5. SEX	6. AGE (In yrs. Is	nst birthday)		R t YEAR	IF UNDER		7. DATE OF	F BIRTH		8. BIRTHP	LACE (State or Foreign
	579-26-9892	2A	1 M 2 F	68	YRS.	MONTHS	DAYS	HOURS	MIN.	June	27/2	6	Wisc	onsin
	9a. FACILITY NAME (If not in			set and number)			, TOWN O	R LOCATIO	ON OF DE				TY OF DEA	ATH
8	6200 E. For		Garth				Colum	bia				H	oward	L
DIRECTOR	RESIDENCE OF DEC	10b. COUNT	v		40 - 017	v mana								
Ē	Maryland	100.00011	Howard		10c. C11	COL	mbia						1	10d. INSIDE CITY LIMITS?
5	10e. STREET AND NUMBER		TOWALG			COIL								YES 2 NO
10e. STREET AND NUMBER 6200 E. Foreland Garth 10f. ZIP CODE 21045 United States 11. MARITAL STATUS 11. MARITAL STATUS 12. WAS DECEMENT EVER IN U.S. ARMED FORCES? 1X YES 2 NO 15. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No- If yes, specify Cuben, Maxican, Puerlo Rican, etc.) 16. RACE — American Indian, Black, White, etc.														
N.	11. MARITAL STATUS	CICIO	12. WAS DECEDEN	T EVED IN II C A	PMED	140	WH C DEC				(Specify Yes			
正	1 Never Merried 2	Married	FORCES? 1	X YES 2	NO		If yes, spe	ectfy Cuba	n, Maxicar	n, Puerto Ric	an, etc.)	or No-		– American Indian, White, etc.
ВУ	3 Widowed 4 X Dive	orced	IF YES, GIVE W	WWII			1 YES	2 🔀 NO	Specify	r:			Specify:	White
8	15. DEC	EDENT'S EDU	CATION	16a. D	ECEDENT'S	USUAL O	CCUPATIO	N .		16b. K	IND OF BUS	INESS/IND	USTRY	7112200
Ш	Elementary/Secondary (6		College (1-4 or 5 -	- Hi	Give kind of e. Do NOT u	se retired.)	aunng mo:	st or wonan	g					
MP	unknown			S	alesn	nan				A	utomo	bile	S	
COMPLETED	17. FATHER'S NAME (First, M							111			idle, Maiden S	,		
BE	William	Olso	on						rtru				house	;
0	19a. INFORMANT'S NAME (1	,,		11							City or Town			
	Rob Roberts					_		_	arth	Colu	mbia 1	$^{\text{MD}}$ 21	044	
	20e_METHOD OF DISPOSITION 1 © Burlat 2 © Cremation 3 © Removat from Stata 4 © Donation 5 © Other (Specify) Carry componery or other place) Carry componery or other place (Carry componer)													
	4 Donation 5 Other (Specify) Garrison Forest Veterans 6-30 Owings Mills, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE													
	1	0	00 -								neral			
	23. PART I. Enter the d	leases or	complications the	anunad the d	anth Da		112	old	Colu	mbia	Pike	Elli	∞ tt	City 21043
	shock, or h	aart fallure.	List only one cau	se on each lin	a.	not antei	tne mod	da ot dyi	ng, auch	n aa cardle	c or reepir	atory em	ent,	Approximate Interval Between
	IMMEDIATE CAUSE (Fir disease or condition		:^	- 0		\odot		1		-1				Onset and Death
	resulting in death)	7	a. Henre	OR AS A CONSE	OUIENCE O	100	Dira	-m	17	ulm	R,			houghs
-			b. Ends	+001	Cal	1.	1.	10.0	1 ie	05. 0				7
ERTIFICATION	Sequentially list condit if any, leading to imme	lona,	DUE TO	OR AS A CONSE	GUENCE O	F):	C 10	2	ous	evse				12003
3	cause. Enter UNDERLY	ING	c											
H	that initiated events resulting in death) LAS		DUE TO	OR AS A CONSE	OUENCE O	F):								
	resulting in death) LAS		d											
CC	PART II. Other algolfice	nt condition	a contributing to	deeth but not	reaulting	In the ur	nderlylng	ceuse g	lven in i	Part I. 2	4a. WAS AN A	WTOPSY	24b. W	VERE AUTOPSY FINDINGS
MEDICAL	Congartue	- hear	t fail u	re						1.	PERFORM	-	A	MATLABLE PRIOR TO COMPLETION OF CAUSE
			V				/			— I.	YES 2	LINU		F DEATH?
	DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF DEA	ATH YE	S M	ио П	UNC	ERTAIN				'	YES 2 JAN
IAI	25. WAS CASE REFERRED TO EXAMINED?				CE OF DEA			0.10						
SIC	1 TES 2 NO	- 10	HOSPITAL: 1 Inpatiant 2	ER/Outpatient	3 DOA	OTHE		5 □- #€	aldence (6 Other (5	Specify)			
PHYSICIAN:	27. MANNER OF DEATH		28a. DATE OF (Month, De		28b. TIM	E OF URY	28c. INJL WOR	JRY AT		28d. DESCF	RIBE HOW IN	JURY OCC	URED	
BY		Pending Investigation				М	1 🗆 Y	ES 2	NO	-				
8	3 Suicide 8 Could not be determined determined determined 28s. PLACE OF INJURY — At home, term, street, factory, office 28s. LOCATION (Street and Number or Rural Route Number, City or Yown, State)													
1								_						
COMPL	(Check only		CIAN: To the best of											
8	ZEMEDI			amination and/or	investigatio	n, In my c	pinlon, de	eth occur	ed at the t	time, data an	d placa, and	dua to the	cause(a) a	and manner as stated.
BE	296. SIGNATURE AND TITLE	OF CERTIFIE		D	- the	M	=	-	NSE NUM			29d. DATE	SIGNED (M	fonth, Day, Year)
5	20 NAME AND ADDRESS	- / \	2	He	nan	26	>		51.	473		7	me "	1 1953
.	30. NAME AND ADDRESS OF	PERSON WH	CAUS	L OF DEATH (ITE	M 27) (Type,	Print)					-			

RE, MS 476 THEM WICK UNE W A RECUSTRANS SIGNATURE THE DEVELOP REMODELL

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defached for use as the burial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

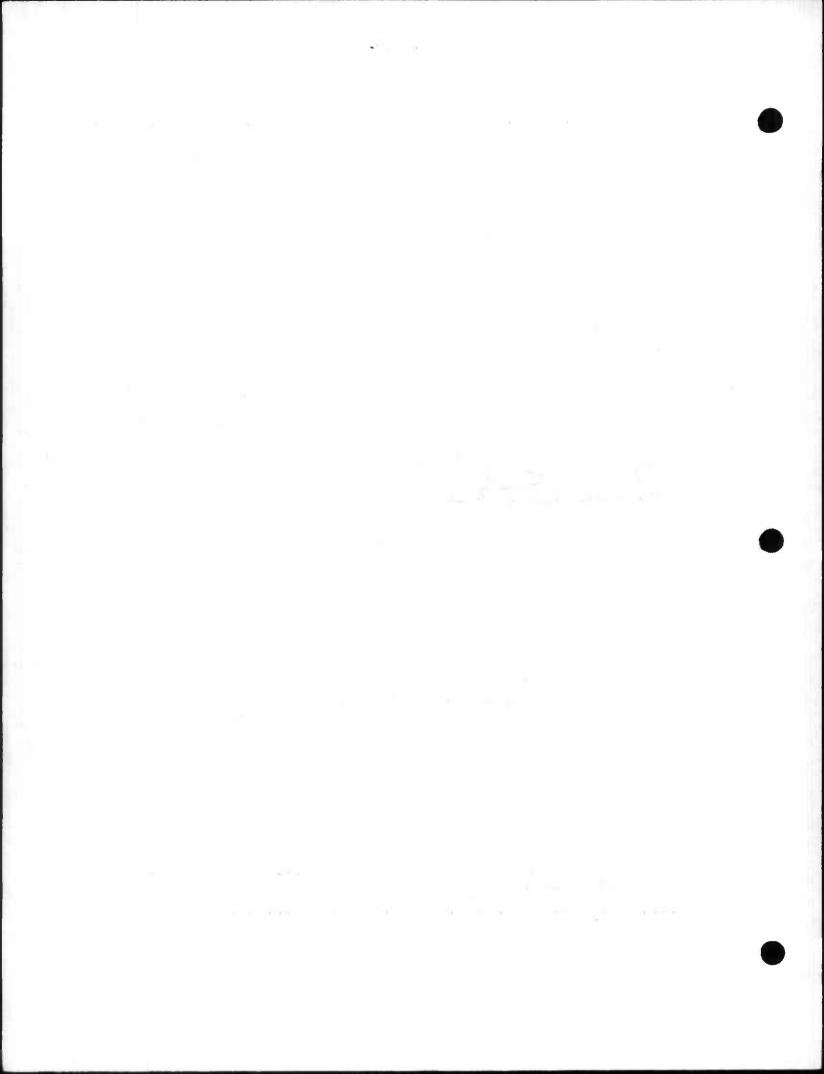
IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM	MENT OF H	EALTH AND	MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH			
	Gay	Owens					4, 1995	8:10 p. m			
				UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. 8	BIRTHPLACE (State or Foreign Country)			
	727-77-1212		75 YRS.	WINS CATS	HOURS MM.	Aug. 24,	1919 W	esť Virginia			
~	9e. FACILITY NAME (If not institution, give atreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH										
DIRECTOR	Wellington Manor Nu	rsing & Reh	ab. Cntif.	C2	linton		Princ	ce George's			
3EC	10a. STATE 10b. COUNTY		10c. CITY, T	OWH OR LOCAT	ION			10d. INSIDE CITY			
	Virginia		Harr	isonbu	rq			1 X YES 2 NO			
M	10e. STREET AND NUMBER				ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?			
FUNERAL	2850 Virginia Ave.				22801		U.S.A	<u>A.</u>			
FU	11. MARITAL STATUS 12 1 Never Married 2 Married	2. WAS DECEDENT EVER IN FORCES? 1 YES	2 ∑ NO	If yes, spi	ecity Cuben, Mexica	NIC ORIGIN? (Specify Year, Puerto Rican, atc.)	a or No- 14.	RACE — American Indian, Black, White, etc.			
ВУ								specity: nite			
ED	15. DECEDENT'S EDUCATI (Specify only highest grade con	TON	16a. DECEDENT'S US	UAL OCCUPATION)N	16b, KIND OF BU					
ET		Cotlege (1-4 or 5+)	(Give kind of work life, Do NOT use re		at of working						
COMPLETED	12		Manager			Insuran	ice Comp	pany			
8	17. FATHER'S NAME (First, Middle, Leat)					ME (First, Middle, Meiden	Sumame)				
BE	Clay Day					Lewis					
9	John Ray Owens					Route Number, City or Tow		(e)			
Ì		Look	PLACE AND DATE OF			ldorf, MD	20602 CATION — City				
	20a, METHOD OF DISPOSITION 1 & Burial 2 Cremetton 3 Removal 4 Donation 5 Other (Specify)	I from State	etery, cremetory or other est Haven	place)				isonburg, VA			
	21. SIGNATURE OF FUTERAL SERVICE LICEN		se navar			CILITY Lee Fu	neral H	Iome Inc			
8	· MATE)				ander Ferr		ione, Inc.			
-	21 PART V Enter the diseases, or com	nolications that caused	the death. Do not	ICTINEC	on, MD 20	J/35 ·		Approximata			
	shock, or heart failure. List	t only one cause on e	och line.	antar the mo	A .	sa cardiac of reap	matory arrest,	Interval Between Onset and Daath			
	IMMEDIATE CAUSE (Finel disease or condition	Omo	Ma.	2 ~	ah and	rate in		Onset and Death			
	resulting in death) s	DUE TO (QR AS A	CONSTQUENCE OF):	0	ereger	00010011					
Z	C 1	cna,	Mack	Can	reer U	2 tan	enea	2			
E	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF		7 -	00	. 1				
5	CAUSE (Disease or Injury	W/S	CONSEQUENCE OF:	Se V	WATO	Moon	roll				
CERTIFICATION	that initiated events resulting in death) LAST	Mode	CARCA'	0	hlos	du Q					
E	_ d_	- Interven	2 MINO		sco	-cw-	<u> </u>				
Ä	PART II. Other eignificant conditions c	ontributing to deeth be	ut not resulting in t	he underlying	ceuse given in	Part I. 24a, WAS AN PERFOI		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO			
8						1 YES 2	R □ NO	OF DEATH?			
M	DID TODACCO LICE CONTINUE	THE TO CALLER O						1 YES 2 NO			
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIB		F DEATH YES		UNCERTAIL	NU					
SICI	EXAMINER?	IOSPITAL:	0	THER:	e d 🗆 Booldoore	4 F3 ON 4044					
H	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME O	F 28c, INJ	URY AT	6 ☐ Other (Specify) 26d. DE\$CRIBE HOW I	INJURY OCCURE	ED			
ВУ Р	1 Accident 5 Pending	(Month, Day, Year)	INJUR		RK7 'ES 2 NO						
	2 Accident Investigation 3 Suicide 5 Could not be	28e. PLACE OF INJURY building, etc. (Speci	— At home, ferm, streetfyl	nt, factory, office		281. LOCATION (Street City or Yown, Stete)	end Number or R	ural Route Number,			
COMPLETED	4 Homicide determined	3,000				City or rown, Stelle)					
29e. CERTIFIER (Check only 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(a) and manner ea stated.											
ON	2 MEDICAL EXAMINER: C	On the beals of examination	end/or investigation, i	n my opinion, d	eath occured at the	time, date end place, er	nd due to the cer	use(s) end manner ea stated.			
BE C	296 SIGNATURE AND TITLE OF CERTIFIER	- 11	100 0		29c. LICENSE NUI	MBER	29d. DATE SIG	ONED (Month, Day, Year)			
TO B	moun	NOX	Heway	12	1)-24	535	June	e 26, 1995			
-	30. NAME AND ADDRESS OF PERSON WHO C				0101 01	dule se					
F		Laxmi N. Berwa, M.D., 7700 Old Branch Ave., C101, Clinton, MD 20735									
	TI DRIE ER ED (Month Cay Mar)	J 32. REGISTRAB'S SIGN/	ATURE								
	JUN 2 8 1995	32. REGISTRAP'S SIGNA	orkardell								

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as be filed within 72 hours after death with the State Debt, of Health and Mental Hydiehe prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the be filed within 72 hours after death with the State Dept. of Health and M.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Inju

STATE OF	MARYLAND / DEPARTMENT	OF HEALTH AND	MENTAL HYGIENE
	CERTIFICATE	OF DEATH	REG NO

	1 - FOR STATE REGISTRAR	STATE OF MARYLAI	ND / DEPARTMI			MENTAL HYGIEN				
	1. DECEOENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3.	TIME OF DEAT	ГН
	CHARLES EDWIN	ORRISON				JUNE 20		EAR S	1:49	Ам
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) Country (Month, Day, Year)									oreign
	3/9-0/-099/ 1 M 2 F /8 YRS. Jan 31,1917 Vir									
œ	9a. FACILITY NAME (If not institution, give stre				R LOCATION OF DI		9c. COUNTY			
DIRECTOR	Fort Washingto	m Medical	Center F	ort I	wasning	ton	Prin	ce (George	e's
REC	10e. STATE 10b. COUNTY			WN OR LOCAT	ION			10	d. INSIDE CITY	,
ā	Maryland Princ	e George's	Fo	ort Wa	ashingt	.on		1	YES 2	No
AAL	10e. STREET AND NUMBER	7		101.	ZIP CODE				T COUNTRY?	
FUNERAL	8809 West Fort				20744				State	
	1 Never Merried 2 X Married	12. WAS DECEDENT EVER IN U FORCES? 1 YES	2 12/10/2	If yes, spe	city Cuban, Mexica	NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	or No- 14.		American Indicates American Indicates Indicate	en,
BY	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2X NO Specify: Specify: White								ite	
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade or	(TION 1	6a. DECEDENT'S USUA (Give kind of work d	lana durina ma	N st of working	16b. KIND OF BUS	SINESS/INDUS	TRY		
LE	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use retin	red.)			_		-	
M	17. FATHER'S NAME (First, Middle, Last)		Relliger	ation		nic Self		Tole	ed	
8	Walter Herman	Orrison				ME (First, Middle, Maiden Hazel Va:	,	100		
BE	19a. INFORMANT'S NAME (Type/Print)	01110011	196. MAILING ADDI	RESS (Street or		Route Number, City or Tow			_	
5	Betty Orrison		1			ote Terr			sh. N	Md
	20e, METHOD OF DISPOSITION 1 Disposition 3 Disposition 3 Disposition 3 Disposition 3 Disposition 3 Disposition Dis	20b. P	LACE AND DATE OF DIS	POSITION (Na		23,1995				
	4 Donation 5 Other (Specify)	Ep	iphany E	pisco	pal Ce	m Fu	Fore	stvi	llle,	Md
	21. SIGNATURE OF FUNERAL SERVICE LICE	56.		22. NAME AN	D ADDRESS OF FA	ourLee Fu	neral	Hon	ne, Inc	
	Alleman C	Pales		6633	Old Al	exander 1	Ferry	o Rd 0735	Clir	nton
	23. ART i. Enter the diseases, or co shock, or heart failure. Li	mplicatione that caused to st only one cause on eac	he daath. Do not er	nter the mod	de of dying, suc	h aa cardlec or respi	ratory arrest	,	Approxima	
	iMMEDIATE CAUSE (Final disease or condition		umpula						Onset and	
J	resulting in death) a.	DUE TO (OR AS A C							(wh	
_	<u> </u>	50E 10 (011 A5 A C	onscodence or).							
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	OUE TO (OR AS A C	ONSEQUENCE OF):							
S	cause. Enter UNDERLYING CAUSE (Disease or Injury								 	
E	that initiated events resulting in death) LAST	DUE TO (OR AS A C	ONSEQUENCE OF):							
CEI	d.									
AL	PART II. Other aignificant conditions	contributing to deeth but	not resulting in the	underlying	cause given in	Part I. 24s. WAS AN PERFOR			RE AUTOPSY FI	
DIC		ardina	gar K	11)	1 _ YES 2		co	MPLETION OF C	AUSE
M		Septicol	2000	· Col	L		41	1 (YES 2	00
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH (Ch	□ NO □	UNCERTAIN	18				
Sic	EXAMINER?	HOSPITAL:	OTI	HER:						
HYS	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME OF	Nursing Home		6 Other (Specify) 28d. OE\$CRIBE HOW II	JURY OCCUR	FO		
ВУ Р	Netural 5 Pending Accident Investigation	(Month, Dey, Year)	INJURY	WOR		200.000				
ED B	3 Suicide 6 Could not be	28e. PLACE OF INJURY — building, atc. (Specify)	At home, farm, street,	factory, office		281. LOCATION (Street e City or Town, State)	nd Number or I	Rural Route	Number,	
	4 Homicide determined					ony or lown, oralloy				
COMPLET		AN: To the best of my knowled								
S I	2 MEDICAL EXAMINER:	On the basis of examination e	nd/or investigation, in r	my opinion, de	ath occured at the	time, date end place, en	d due to the co	ruse(e) en	d manner ee si	lated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER	XI			29c. LICENSE NUM D 1 6 1 2 9		29d. DATE SI	GNED (Mo	o 199	-
2	30. NAME AND ADDRESS OF PERSON WHO	ALL COMPLETED CHARLES	ATEN CO.		טוטוב;	,	D 301	- Z	0 199)
	WILLIAM I OFTC	EN 0121 DIG	ATAMAY		00 CLI	NTON, MD	20735			
	31. DATE FILED (MONTH), Day, Year) JUN 2 8 1995. 32. REGISTRAR'S SIGNATURE July Day World Day, Year)									



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STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Vehemiah err 95 7.45 P. M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign 219-53-2 DAYS 1 M 2 - F YRS. MCT Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DORCHESTER RESIDENCE OF DECEDENT DIRECTOR Ca Dorchester ton, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY 1 X YES 2 NO permit. FUNERAL 10a. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 20-G hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-transit 21 Avenue 6 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-11. MARITAL STATUS RACE — American Indian, Bleck, White, etc. If yes, specify Cuban, Maxican, Puarlo Ricen, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced CD. 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ᆸ idary (0-12) College (1-4 or 5+) COMPL . Ne WORKER anning notified at once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surn H INFORMANT'S NAME (Type/Print) 19b, MAILING ADDRESS (Street and Number or Rural 86 2 pe 20a. METHOD OF DISPOSITION

1 Description | Burlel | 2 | Cremation | 3 | Re 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Rev 5 Other (Specify) medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hone HENRY FUNERal SIO Wash Notan amby 23. PART. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory strest, shock, or heart fallure. List only one cause on each line. Approximata interval Between 0 filled **IMMEDIATE CAUSE (Final** Onset and Death executed with the cremation, disease or condition Sepsis completely 6-21-95 resulting in death) other traumatic event, DUE TO (OR AS A CONSEQUENCE OF) bunial, iobab CERTIFICATION Sequantially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): has been signed by the attending physician a Dept. of Health and Mental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING the death certificate CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 Injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO CDMPLETION OF CAUSE OF DEATH? Vascular direase 23 shows any 1 TYES 2 NO Keiner 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES □ NO □ UNCERTAIN □ 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one, ltem. r this certificate h OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Realdence 6 Other (Specify) 9 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural DIRECTOR: After the hours after death w t YES 2 NO В Investigation 2 Accident 28a. PLACE OF INJURY — At homa, term, strast, tactory, offica building, atc. (Specify) .00 3 Suicida 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) ED. 8 Could not be 28 4 Homicide COMPLET Hem 29a. CERTIFIER t CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. THE HOSPITAL OF THE FUNERAL DIFFERMENT TO THE = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: I 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and manner as stated, 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2 14349 95 Cannan 122 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Eyup Tanman, M.D 15 Franklin Street Cambridge, MD 21613 JUN 2 3 1995 32 REGISTRAR'S SIGNATURE Julia Davidear Rardall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

TO BE COMPLETED BY FUNERAL DIRECTOR

BALLIMORE, MARITAND 21213-0020	4 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Deat, of Health and Mental Hymlene prior to burial, cremation, or removal	e medical examiner must be notified at once.
100 CO 10	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi be filled within 72 hours after death with the State Dent, of Health and Mental Hynlene prior to burlat, cremation, or removal	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

2 VOI RE,
31. DATE FILED (Month, Day, Year)
JUN 2 6

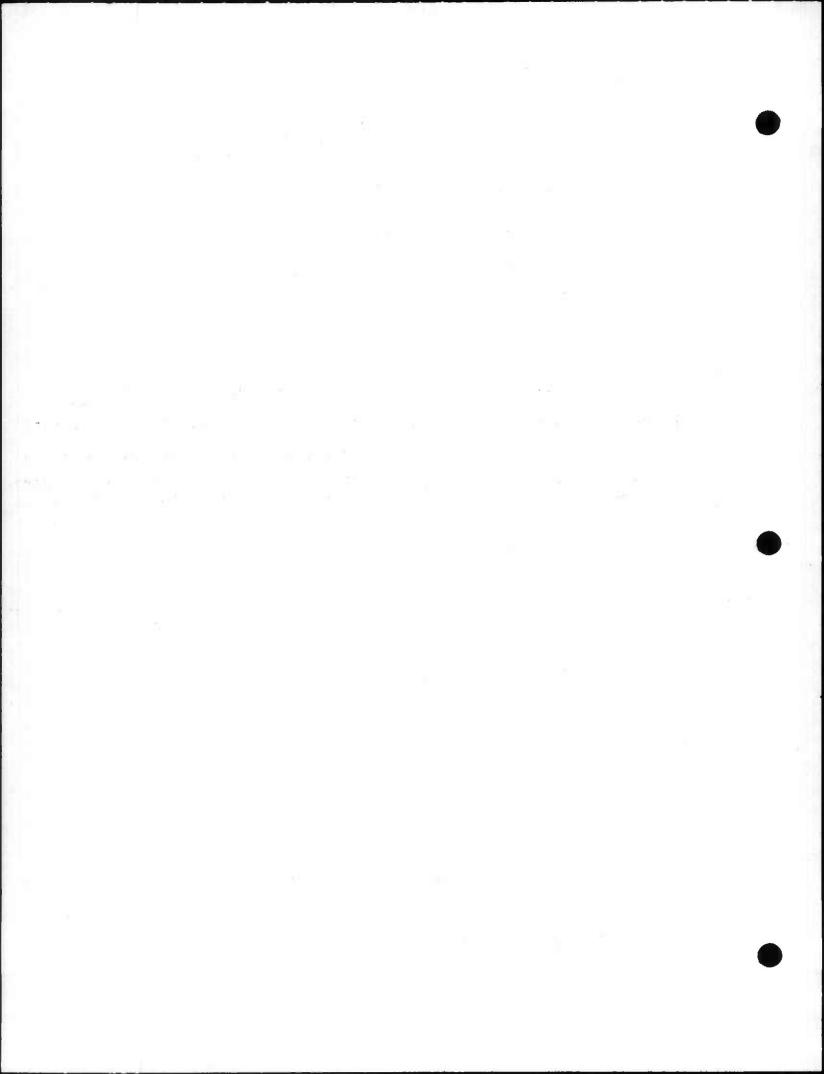
Researce

						90	20688
FOR 1 - STATE REGISTRAR	STATE OF MARYLAND	DEPARTM					
1. DECEOENT'S NAME (First, Middle, Last)		ENTIFICA	AIE OF	DEATH	REG. NO		
Gertrude 4. SOCIAL SECURITY NUMBER	H .		Plur	nmer	June &	21 199	5 655 DH
438-14-6948	5. SEX 6. AGE (In yrs. las		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	July 21,	1919	IRTHPLACE (State or Foreign ountry) Jouisiana
9e. FACILITY NAME (If not institution, give str				OR LOCATION OF D		9c. COUNTY C	OF DEATN
Shady Grove Ad	ventist Hospi	tal R	ockvi	11e		Mon	ntgomery
10e: STATE 10b. COUNTY		10c. CITY, TO	WN OR LOCAT	TION			10d. INSIDE CITY
	ntgomery	Ro	ckvi1	1e			1 YES 2 X NO
10e. STREET AND NUMBER			101	ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
13525 Glen Mi				2085			S.A.
11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. AR FORCES? 1 YES XXXIII YES, GIVE WAR OR DATES	MED 10	It yes, sp	ENDENT OF HISPA ecify Cuben, Mexica 2 X NO Specif	NIC ORIGIN? (Specify Yea an, Puerto Rican, etc.) y:	or No— 14. F	RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUC (Specify only highest grade of		CEDENT'S USU	AL OCCUPATIO	ON est of working	16b. KIND OF BUS	SINESS/INDUSTR	ty
Elementary/Secondary (0-12)	College (1-4 or 5 +)	Do NOT use ret etail			Camera	& Pho	oto Supplie
17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Maiden	Surname)	
John Stanga	<u>a</u>			Ne1	lie Des	mond	
19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Tow		20030
Thomas E. Plum	mer, Jr.	13525	Glen	Mi11 F	Road, Roc	kville	, Maryland
20e. METNOD OF DISPOSITION 12C Burlal 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	val from State cometent on	IND DATE OF DI	lonel		1	CATION - City of	v Town, State vn, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE		22. NAME AN	ID ADDRESS OF FA	CILITY		
Olini L.	Moleon ath		2640	1 Ridge	Road Da	mascus	Funeral Homes, Maryland
	omplications that caused the de list only one ceuse on each line	ath. Do not e	enter ths mo	de of dying, suc	h ss cardisc or respi	ratory erreat,	Approximats interval Between
iMMEDIATE CAUSE (Fins) disesse or condition resulting in deeth)	Pulmonar	ry (sed	ema			Onset and Dasth Days
	OUE TO (OR AS A CONSEC	DUENCE OF):	4	^	0		
Sequentially ilst conditions,	Houte 1	mo	and	ial	Sujanc	line	
if sny, lesding to immediate csuse. Enter UNDERLYING	OUE TO (OR AS A CONSEC	QUENCE(OF):			4		
CAUSE (Disesse or injury that initieted events	DUE TO (OR AS A CONSEC	DIJENCE OF:					
resulting in death) LAST							
PART ii. Other significant conditions	contributing to death but not re	esulting in th	e underlying	Cause given in	Part I. 24s. WAS AN	ALITOREY	245 WEDE ALCONOUS PAIDURES
		ounting in th	o dilderiying	g codeo given in	PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
					1 _ YES 2	XNO	OF DEATH?
DID TOBACCO USE CONTR	IBUTE TO CAUSE OF DEA	TH VEC I	J NO F	UNCERTAIL			1 TES 2 NO
25. WAS CASE REFERRED TO MEDICAL		E OF DEATH (C		UNCERIAL	· ⊔		
	HOSPITAL: 1 Inputient 2 ER/Outputient 3	OT	HER:	6 Qualdanc-	6 Other (Specify)		
27. MANNER OF DEATN	26e. DATE OF INJURY	28b. TIME OF	28c, INJ	URY AT	5 ☐ Other (Specify) 28d. DESCRIBE NOW II	JURY OCCURE)
1 Natural 5 Pending Investigation	(Month, Day, Year)	INJURY	WO	RK? 'ES 2 NO			
2 Accident Investigation 3 Suicide 6 Could not be determined	28e. PLACE OF INJURY — At hos building, etc. (Specify)	me, term, street	, factory, office	,	26t. LOCATION (Street a City or Town, State)	nd Number or Ru	ral Route Number,
29e. CERTIFIER							
	IAN: To the best of my knowledge, del :: On the basis of examination end/or in						se(e) end manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER	Λ.			29c. LICENSE NUI	ABER	29d. DATE SIGN	NED (Month, Day, Year)

340

TRANS SIGNATURE ROLLING

22, 1995



ITEMS: 23 PART I. 27, PER MEO FILM G-725 7/21/95 t.t

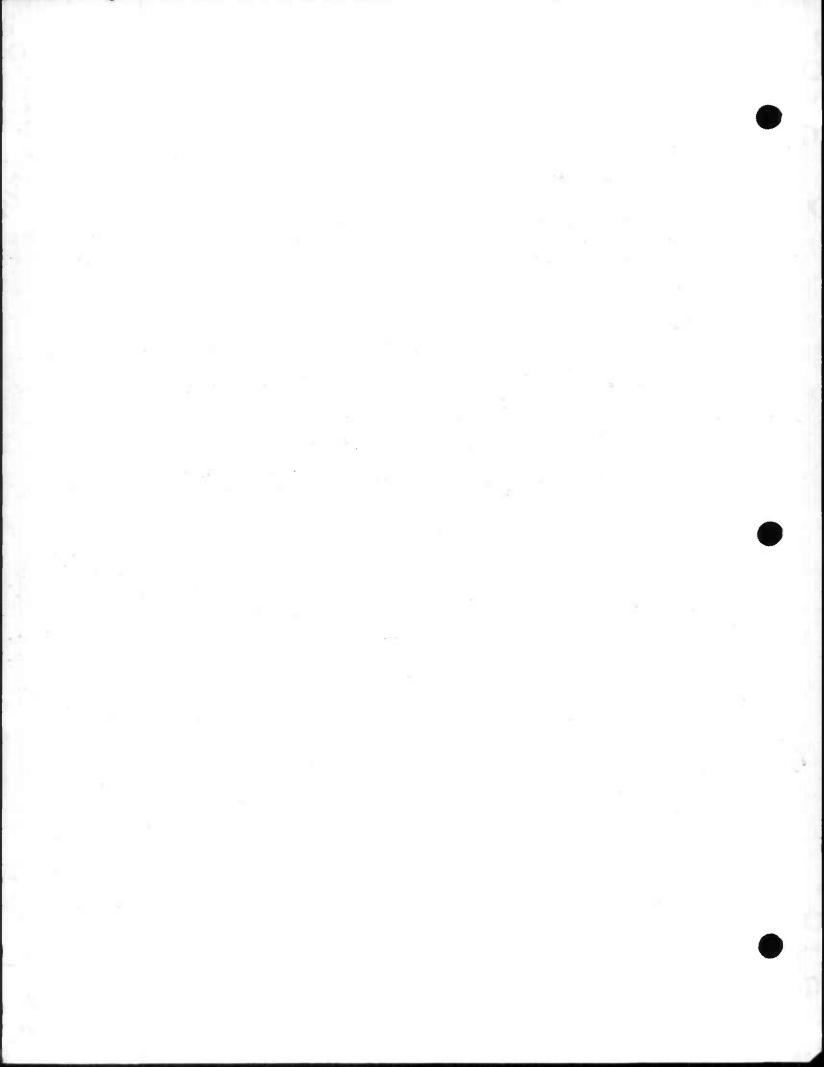
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DERRICK CONRAD PERRY JUNE 18 1995 5:28 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTNPLACE (State or Foreign (Month, Day, Year) May 28, 0/1 1XXM 2 | F DAYS HOURS 579-08-5299 33 YRS. Wash., D.C. 1962 Pages 1, 2, 3 should 90. FACILITY NAME (If not institution, give street end number)
PRINCE GEORGES HOSPITAL CENTER 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH CHEVERLY PRINCE GEORGES DIRECTOR RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT 10c CITY TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince Georges Hillside 1 X YES 2 NO permit. 10a. STREET AND NUMBER FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? completely filled in by the funeral director, page 5 should be detached for use as the burial-transit 5235 Marlboro Pike #104 20743 United States Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1XXNever Married 2 Married If yes, specify Cuban, Mexicen, Puarto Rican, etc.)

1 YES 2 XNO Specify: BY Specify 3 Widowed 4 Divorced Black 16e. DECEDENT'S USUAL OCCUPATION 8 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Spe COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) 12 Truck Driver Transportation 17. FATNER'S NAME (First, Middle, Last) ts. MOTNER'S NAME (First, Middle, Maiden Surname) te James H. Perry BE Marva R. Miller notified 19e. INFORMANT'S NAME (Type/Print, 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Kimberly Roane 10721 Willow Oaks Dr., Mitchellville, Md 20721 (sister) pe 20a METNOD OF DISPOSITION
1 D Burlel 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must emetery, cremetory or other place)
HARMONY MEMORIAL PARK 4 Donation 5 Other (Specify) _ 6/24 LANDOVER, MARYLAND examiner 21. SIGNATURE OF FUNERAL SERVICE LICEN 22. NAME AND ADDRESS OF FACILITY hours after death. ALEXANDER S. POPE FUNERAL HOMES M859 OTA 5538 Marlboro Pike, Forestville, Md 20747 medicai 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximeta ahock, or heert feliure. List only one ceuse on each line. Interval Between 6 IMMEDIATE CAUSE (Final **Onset and Death** the diseese or condition_ SEIZURE DISORDER resulting in death) event. executed with DIVISION OF VITAL RECORDS, P.O. BOX 68769 DUE TO (OR AS A CONSEQUENCE OF): the attending physician and con Mental Hygiene prior to bunal, other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE MEDICAL 24s. WAS AN AUTOPSY been signed by that, of Health and P that any YES 2 NO OF DEATH? Shows 1 TYES 2 T NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) The the State I HOSPITAL:
1 □ Inpatient XXER/Outpatient 3 □ DOA OTHER: 1 X XES 2 NO ATTENDING PHYSICIAN: 4 Nursing Nome 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY with t 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED marked, INJURY 1 XX Natural 1 YES 2 NO DIRECTOR: After the hours after death v B 2 Accident Investigation 28e. PLACE OF INJURY — At home, term, street, factory, office 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 99 8 Could not be COMPLETED 4 Homicide 28 R 29e. CERTIFIER 1 _ CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(a) end menner ee stated. FUNERAL WITHIN 72 H HOSPITAL TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: 1 2 💢 MEDICAL EXAMINER: On the beele of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 28h. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE O.C.M.E ▶ JUNE 19,1995 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

diavelen Karlett

1995

1



BALTIMORE, MARYLAND 21215-0020	SICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should thin the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral dit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20

1/19

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

	REGISTRAR		CERTIF	ICATE C	F DEATH	REG	S. NO.			
9	1. DECEDENT'S NAME (First, Middle, Last) There	es T	0	+	,	2. DATE OF DEA	ATH PAYO /	CAFAB	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 5. SE		1 10	310N		NONG	18,1	795	3 10 AM	
		M 2 🛛 F 4	E (In yrs. last birthday) 7 YRS.	MONTHS DAY		7. DATE OF BIRTY (Month, Day, V	bar)	Countr	IPLACE (State or Foreign y) I., D.C.	
	9a. FACILITY NAME (If not institution, give street and	number)		9b. CITY, TOV	N OR LOCATION OF D			UNTY OF D		
DIRECTOR	PRINCE GEORGES HOSPI	TAL CENT	'ER		ERLY	PRINCE GEORGES				
Ä	10a. STATE 10b. COUNTY		10c. CITY	r, TOWN OR LO	CATION				10d. INSIDE CITY	
	MARYLAND PRINCE G	EORGES	UPP	ER MAR			LIMITS? 1 YES 2 NO			
FUNERAL	1011 Fenton Place				101. ZIP CODE 20772	United states				
5		AS DECEDENT EVER	IN U.S. ARMED	13. WAS	DECENDENT OF HISPA	NIC ORIGIN? (Spec	Ify Yee or No-	14. RACE	— American Indian, t, White, etc.	
B⊀		YES, GIVE WAR OR			specify Cuben, Mexic rES 2 X NO Speci		tc.)	Speci Bla	fy:	
TED	15. DECEDENT'S EDUCATION (Specify only highest grade complete	ed)	18e. DECEDENT'S (Give kind of v	vork done during	ATION most of working	16b. KIND (OF BUSINESS/II			
COMPLET	Elementary/Secondary (0-12) Colle	ge (1-4 or 5+)	SECRETA			F.B.	Ι.			
0	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, N	faiden Surname)	1		
BEC	LOVELACE BOYD				ROSA I					
B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Stre	et end Number or Rural		or Town, State, 2	Zip Code)		
2	JOHN POSTON (HU	SBAND)			Place, U				20772	
	20e. METHOD OF DISPOSITION		D. PLACE AND DATE O	F DISPOSITION			DC. LOCATION -			
	1XXBuriel 2 Cremation 3 Removal fro		CEDAR HIL	her place) L CEME	ΓERY	6/23	SUITLA	ND. M.	ARYLAND	
	21. SIGNATURE OF PUNERAL SERVICE LICENSEE	A		22. NAMI	AND ADDRESS OF FA	CILITY			INTERNO	
	23. PART I. Entar the diseases, or complice	uh.	M859	553	XANDER S. 8 Marlboro	Pike .	Forest	tvill.	e, Md 20747	
N	IMMEDIATE CAUSE (Final disease or condition resulting in death)	ACUSEQUENCE OF	c Ca	rded vao	cular o	dise	24.4-	Intarval Between Onsat and Daath		
CERTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated aventa resulting in death) LAST		A CONSEQUENCE OF							
	PART II Other electricant and distance									
MEDICAL	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 2400 24b. WERE AUTOPSY FINDS AMILABLE PRIOR TO COMPLETION OF CAU							AVAILABLE PRIOR TO COMPLETION DF CAUSE		
W I				/		_ ''''	ES 2 DATO	- 1	OF DEATH? 1 YES 2 NO	
	DID TOBACCO USE CONTRIBUT	E TO CAUSE (OF DEATH YE	S P NO	☐ UNCERTAI	N 🗆			1 123 2 1 110	
M	25. WAS CASE REFERRED TO MEDICAL	/	26. PLACE OF DEAT							
Sic	l 1/	PITAL: patient 2 ER/Ou	tpatient 3 DOA	OTHER:	iome 5 🗆 Residence	8 Other (Specific	v)			
Y PHYSICIAN:	1 Netural 5 Pending	(Month, Day, Year)	28b. TIME	OF 28c.	INJURY AT WORK?	28d. DESCRIBE		CCURED		
ED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	building, atc. (Sp.	IY — At home, farm, a			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
91	25s. CERTIFIER									
COMPLETED	Check only 2 GERRY YING PHYSICIAN: To								end menner ee stated.	
BE	296. SIGNATURE AND TITLE OF CERTIFIED	Luger	na.		29c, LICENSE NUI	MBER L30	29d. DA	IE SIGNED	(Month, Day, Year)	
٩	30. NOTE AND ADDRESS OF PERSON WHO COMP	LETED COURSE OF D	EATH (ITEM 27) (Type,	Print)	DI	1-00	0 4	11	2001	
	31. DATE RILED (Month, Day, War)	REGISTRAR'S SIG		009	Kay DUIN	urup.	yor o	1d.	20148	
- 1	JUN 21 1995 July Da	welfor Hard	elle				_			

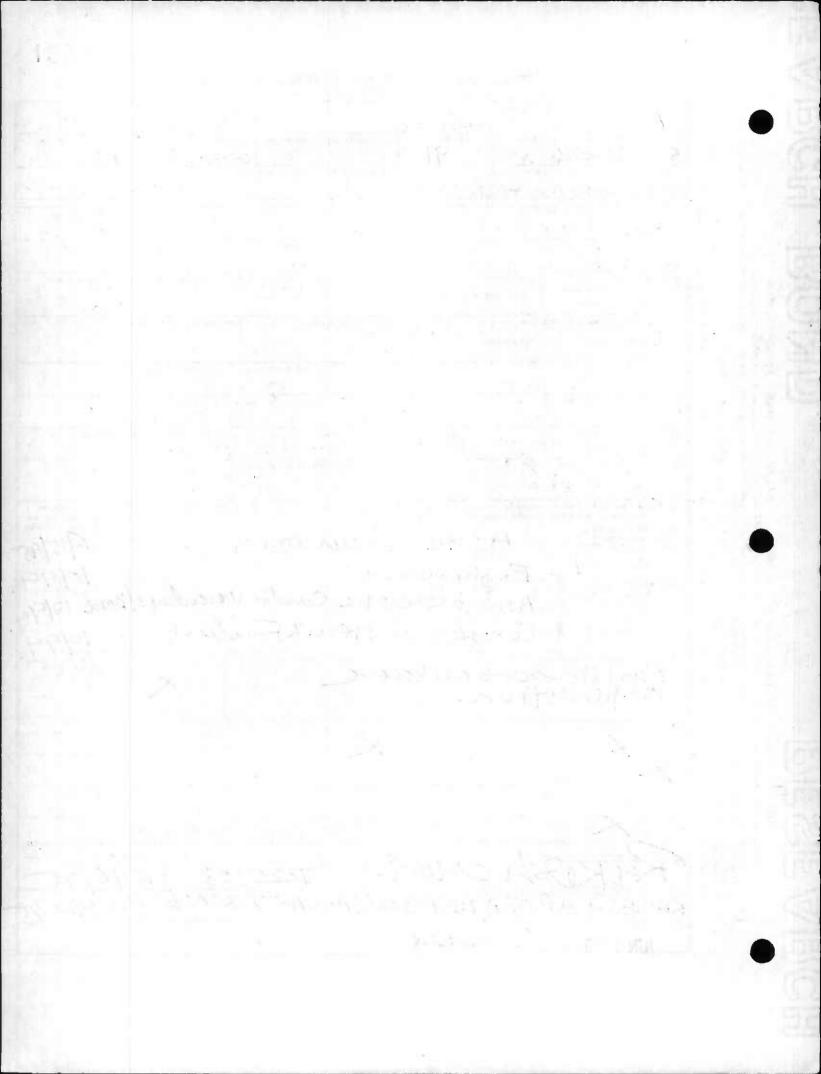
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BALTIMORE, MARYLAND 21215-0020	PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.
BALTIMOF	urs after death. Page 6 m	in by the funeral director, removal.
	TOU	lled i
OF VITAL RECORDS, P.O. BOX 68760	ate be executed with	this certificate has been signed by the attending physician and completely filled in by the fit with the State Dept, of Health and Mental Hyglene prior to bun'al, cremation, or removal.
S, P.O.	e death certific	he attending pl Mental Hygiene
RECORD	w requires that the	been signed by the
OF VITAL	PHYSICIAN: The law	this certificate has with the State Dep.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

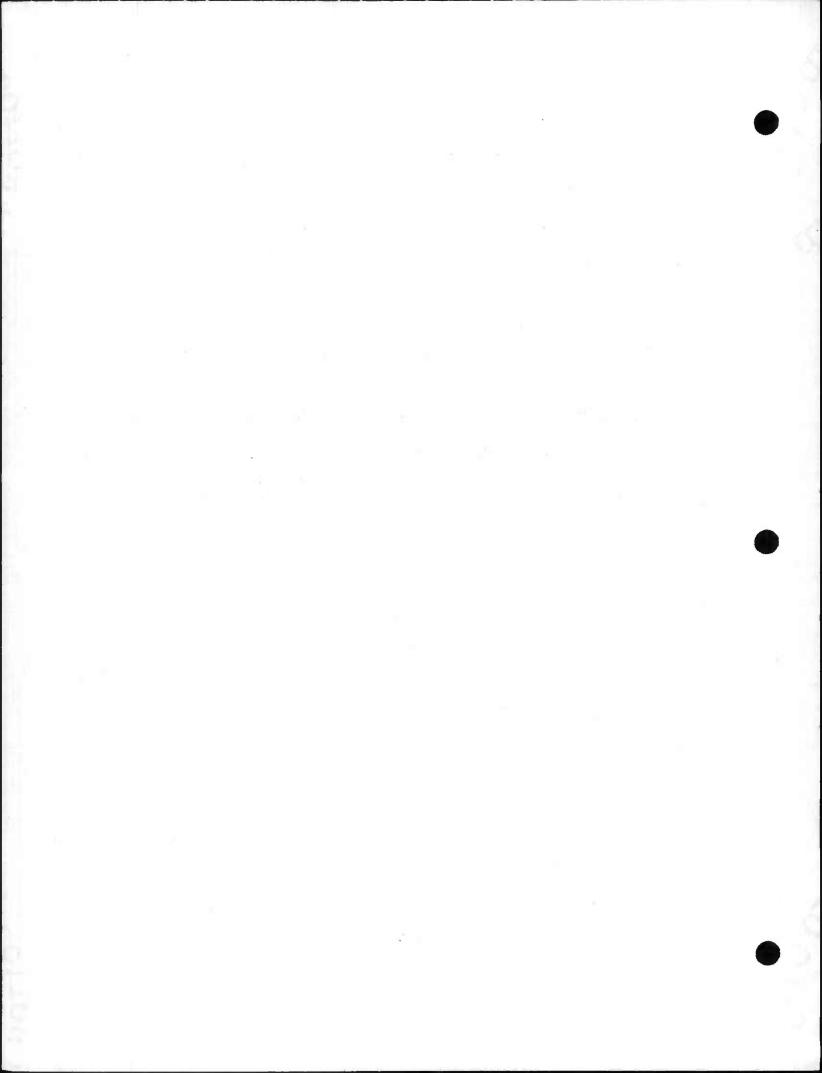
•		1. DECEDENT'S NAME (First, Middle, Lest)	· Pumpi	hreu				2. DATE OF DEATH MONTH	AY - 95 YEAR	3. TIME OF OEATH	
		4. SOCIAL SECURITY NUMBER 578-50-6226	5. SEX 6 AGE	(In yrs. last birthlay)		EAR IF UNI	DER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. Bil	RTHPLACE (State or Foreign	
pinous		9a. FACILITY NAME (If not institution, give		1	96. CITY, TO	OWN OR LOCA	ATION OF D	05-31-04	9c. COUNTY O	F DEATH	
2, 3 s	стов	LAPKIN Chase No RESIDENCE OF DECEDENT	ig. + Rest. (Center	Bowie	9			Prince	George's	
Pages 1,	REC	10a. STATE 10b. COUNT	Y	10c. CI	TY, TOWN OR I	LOCATION				10d. INSIDE CITY	
permit. Pa	ā	Maryland Princ	e George	0x0	on Hill	7				1 YES 2 NO	
	RAI	1907 Deerfield Ct			101. ZIP CODE 20745				10g. CITIZEN OF WHAT COUNTRY? USA		
-0020 ling physician. the burial-transit	BY FUNERAL	11. MARITAL STATUS Never Married 2 Married Marrie	IN U.S. ARMED 2 1 NO DATES	S. ARMED 13. WAS DECENDENT OF HISPAN 17 yes, specify Cuben, Mexica			en, Puerto Rican, etc.)	8 or No.— 14. R B	ACE — American Indian, lack, White, etc.		
215- attendir	ED	15. DECEDENT'S EDUCATION 16e, DECEDENT'S USUAL OCCUPATION 16b, KIND OF BUSINESS/INDUSTRY									
2 al or 6	-ET	(Specify only highest grade	College (1-4 or 5+)		work done duri		rking	P-			
AND he hospital detached for once.	COMPI	10th 17. FATHER'S NAME (First, Middle, Last)		Seli-e	employe		OTHER'S NA	Farme			
# 8 %	ш	Samuel O. Pu	ımphrey					E. Gates	Gurranoy		
MAR e retained e 5 should notified	TO B	190. INFORMANT'S NAME (Type/Print) Clifford C. Pumph	rey					Aoute Number, City or Town			
ORE, s 6 may be ector, page must be		20a METHOD OF OISPOSITION 1/1 X Burlal 2 Crembilion 3 Rem 4 Donation 5 Other (Specify)	noval from State con	b. PLACE AND DATE Telery, compalory or Darna	OF DISPOSITION	ON (Name of		OATE 20c. LC	emple Hi	r Town, State	
Pag Pag		21. SIGNATURE UNERAL SERVICE LI		Daring				S Funeral		.115,114.	
BALT er death. he tunera al.		1111111	Ces ft :		6160) Oxon	Hill	Rd. Oxon	Hill, M	ld. 20745	
for the medic work a mover a mpletely filled in by cremation, or removent, the medic		iMMEDIATE CAUSE (Finel disease or condition resulting in death)	a. A CU	A CONSERVIENCE	nu	emo	mi	9		Approximate intervel Between Onset and Deeth	
. BOX 687 ificate be executed physician and column prior to burial her traumatic of	FICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUETO (OR AS	SEMA CONSEDUENCE OF A CONSEDUENCE OF A	otic	Ca	rdi	o Vascu	landi	10/94 8ax 10/94	
P.O. sath cert attending rial Hygie	CERTIFI	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLY/ING CAUSE (Disease or injury that initiated events resulting in death) LAST Emphy Sequentially list conditions, Indeed to Indeed to Indeed to Indeed to Indeed							10/94		
RDS, at the dea by the att and Menta y Injury,		PART II Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PREFORMED? PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE							24b. WERE AUTOPSY FINDINGS *		
LCOR luires that signed by Health an	EDICAL	Ashi 100	Hom.	4864				1 YES :	No	OF DEATH?	
Sheen Ved	N.	7.0/11/10	11001.						30	1 TYES 2 NO	
VITAL AN: The lav inficate has state Dep	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTAER:	28. PLACE OF					
or the	PHYS	27. MANNER OF DEATH	1 ☐ Inpatient 2 ☐ ER/Out 25e. DATE OF INJURY (Month, Day, Year)	26b. Ti		c. INJURY AT	Residence	6 Other (Specify) 26d. OESCRIBE HOW	INJURY OCCURED		
TENDING PHYS TOR: After this of ther death with	BY	1 Natural 5 Pending Investigation 3 Suicide 6 Could not be	26e. PLACE OF INJUR		M	WORK?	NO NO	28f. LOCATION (Street	and Number or Du	and Barith Mirahas	
vo cal	ETED	4 Homicide e Could not be determined	building, etc. (Spe	icify)		, Ollida		City or Town, State		a route Number,	
로 기가 등	COMPLET		ICIAN: To the best of my know ER: On the basis of examination							sefs) end manner as stated.	
TO THE HOSPIT TO THE FUNERA TO FILE WITHIN 7	BE CC	296. SIGNAPORE AND TITLE OF CERTIFIE	An a	10/1	01		ICENSE NUI			ED (Month, Day, Year)	
PPRE	5	30 NAME AND ADDRESS OF PERSON W	OCOMPLETED CAUSE OF OR	EATH (ITEM 27) (Typ	a. Prints A	111	NT	FOXLN	ROW	EMD207/5	
(5)		31. OATE FILED (Morith, Day, Year)	32. REGISTRAR'S SIGN	MATHE			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	13000	E1400/12	
		JIN 191995	Jalia Devoler	Carlell							



BALTIMORE, MARYLAND 21215-0020	s after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
DIVISION OF VITAL RECORDS, P.O. BOX 68/60	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in

JUN 191995

	1 - FOR STATE REGISTRAR	STAT	E OF N	MARYLA	ND / D	DEPAR RTIF	TMENT	OF H	EALTH AND DEATH	MEN	TAL HYGIEN REG. NO.	E		
	1. DECEDENT'S NAME (First, Mid										ATE OF DEATH		YEAR	3. TIME OF DEATH
	Cabherir	16 1/195	29							1111	UN I		95	6=44 PM
	4. SOCIAL SECURITY NUMBER	5. SEX		8. AGE (In	yrs. last b	oirthday)	IF UNDER	1 YEAR DAYS	IF UNDER 24 HRS.		TE OF BIRTH onth, Day, Year)		8. BIRTHE	PLACE (State or Foreign
	578-10-388	the state of the s		8	1	YRS.	MONTAS	DAYS	HOURS MIN.		UG 7,19	13	It	taly
l l	9a. FACILITY NAME (If not institut								R LOCATION OF D				NTY OF DE	ATH
DIRECTOR	Southern Mary	ENT	pita	1 Cer				lint				Pri	nce (George's
黑		. COUNTY				10c. CITY		OR LOCAT						10d. INSIDE CITY LIMITS?
	Maryland F	Prince Ge	orge	S			D	istr	ict Hei	ghts	3			1 XXYES 2 NO
FUNERAL	5817 Marlbord			_				101.	20747			10g. CITI	ZEN OF W	USA
BY FUR	11. MARITAL STATUS 1 Never Married 2XX Marr 3 Wildowed 4 Divorced	Never Married 2XX Married FORCES? 1 YES 2 X NO					13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: Specify: White, etc.					White, atc.		
Q	15. DECEDE	NT'S EDUCATION		T	16a. DECE	DENT'S	USUAL O	CCLIPATIO	IM		16b. KIND OF BUS	INESC /IND		WIII CC
	(Specify only high Elementary/Secondary (0-12)	heat grade completed,	(1-4 or 5 +		(Give		rork done		st of working					s County
교	6th	Conego	(1-4 01 3 +	"	Cafe	eter	ia M	anag	er				Board	-
COMPLETED	17. FATHER'S NAME (First, Middle,	(Last)								AME (Fig.	st, Middle, Maiden			
E C	Carmel	o Galean	0								nela Spa			
BE	19e. INFORMANT'S NAME (Type/F	Print)			19b. I	MAJLING	AOORESS	S (Street e	nd Number or Rural				Code)	20747
TO BE COM	Joseph C. Pi	.azza							Pike #2					20747 3. Md.
5	20a. METHOD OF DISPOSITION	_		20b. F	PLACE ANI					_			Cily or Tow	
	1 Burial 2 Cremation 3 4 Donation 5 X Other (Spe	City) Entomb	State ment	- Re	esurr	etory or ot	i on	Ceme	tery 6-2	21-0	os Clin	ton	Mary	land
	21. SIGNATURE OF FUNERAL SE	BYICE LICENSEE	OIT C		Juli		22.	NAME AN	D ADDRESS OF FA	CILITY	/J OTIL	con,	rigity	Land
	* Mm 1-10	eles					1 6	160	e P. Kal Oxon Hil	11 R	d. Oxon	H: 1	1. Md	1. 20745
event, me	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final diseases or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):													
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST	c	OUE TO	(OR AS A C	CONSEOU	ENCE OF):							
	PART II. Other eignificant c	onditiona contrib	uting to	death but	t not ree	ulting i	n the un	derlying	cause given in	Part I.	24a. WAS AN			WERE AUTOPSY FINDINGS
MEDICA	urinary t	tract in	fect	5100							PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC														OF DEATH?
ŭ	DID TOBACCO USE	CONTRIBUTE	TO CAI	USE OF	DEATH	+ YE	S 🗆 I	VO M	UNCERTAI	NΠ				I LEG 2 V NO
۱ ک ا ^د	25. WAS CASE REFERRED TO ME				8. PLACE (
SICI/	EXAMINER?	HOSPI 1 (V Inpa		ER/Outpat	tient 3 🗆	DOA	OTHER		5 Residence	8 🗆 0	ther (Specify)			
5 ≥	27. MANNER OF DEATH		DATE OF	INJURY	-	28b. TIME	OF	28c. INJL	JRY AT	-	DESCRIBE HOW IN	JURY OCC	URED	
۲ <u>۲</u>	1 Natural 5 Pend	(Month, De	ey, 10-ar)		INJU	JRY M	1 Y	RK? ES 2 NO						
2 Accident 2 Accident 28e. PLACE OF INJURY — At home, farm, streat, factory, office							261. L	OCATION (Street a	nd Number	or Rural Ro	oute Number.			
히밑		mined	building, (etc. (Specify	у)					C	Ity or Town, State)			2000
PLET	29a. CERTIFIER	NG PHYSICIAN: To II	n heat of	an baanta	des desta		2 La 10 La							
: 🕏														and manner as stated.
8	29b. SIGNATURE AND TITLE OF													
D BE CO	The And The Office of the	Cho	1.0						29c. LICENSE NUI	_	e			Month, Day, Year)
12	30. NAME AND ADDRESS OF PER		TEO CAUS	E OF OFAT	TH (ITEM 2	7) /Tune	Print)		y 50	312	-1		00	9,1995
1	Vincent Ch	en. 913	Pis	cabo	awai	1 R		600	, clin	bor	, MD.	20.	735	
1	31. DATE FILED (Month, Day, Year)	1005	PLIA	RIS SIGNAT	OF PA	delle								



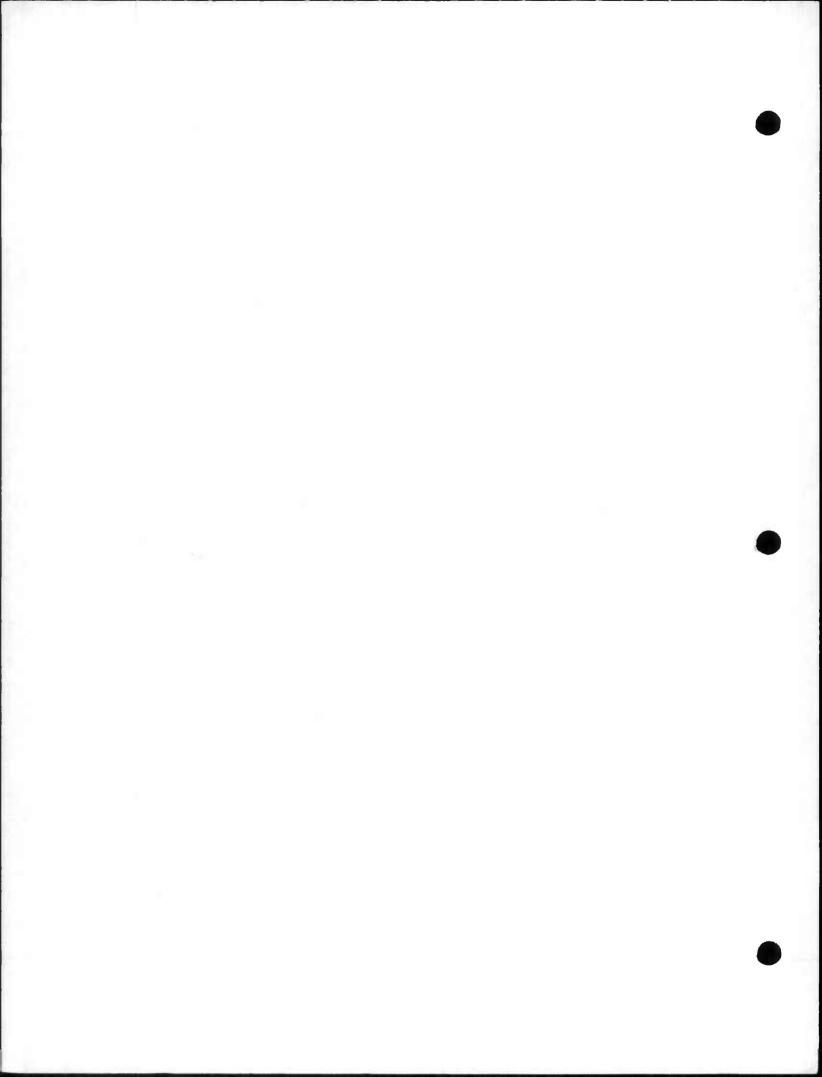
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should thin the State Decr of Health and Mental Hyniene prior to burial, cremation, or removal	d, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the itself and within 72 hours after death with the State Deut of Health and Merital Hyriene prior to burial cremation or removal.	IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other trau

STATE OF	MARYLAND /	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIENE
	CE	ERTIFICATE	O	F DEAT	'H		REG NO

	1 - FOR STATE OF MARY	LAND / DEPARTMEN CERTIFICAT	TOF HEALTH AND	MENTAL HYGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	AK		2. DATE OF DEATN	3. TIME OF DEATH		
				June 17 1	1995 1730 PM		
	577-08-1721 1 M 3 D F	MONTHS	ER 1 YEAR IF UNDER 24 HRS. B DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	BIRTNPLACE (State or Foreign Country)		
	377-00-1721	40	TY, TOWN OR LOCATION OF DI	Jan 8, 1949	Cambodia		
OR	Lorien Columbia Nursing & Rehabil	THEET	Columbia		OWArd		
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	10c. CITY, TOWN	LOS LOS TION				
DIRECTOR	Maryland Prince George's			10d. INSIDE CITY LIMITS?			
	100. STREET AND NUMBER		lyattsville	1 40-	1 ☑ YES 2 ☐ NO CITIZEN OF WHAT COUNTRY?		
N.	5118 Kenilworth Avenue		20781		ambodia		
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER	R IN U.S. ARMED 1:		NIC ORIGIN? (Specify Yes or No-			
	1 Never Married 2 Married FORCES? 1 YE	S 2 X NO	If yes, specify Cuben, Mexica 1 ☐ YES 2 🏋 NO Specifi	in, Puerto Rican, etc.)	Black, White, atc. Specify:		
0 3 & Widowed 4 Divorced							
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	18a. DECEDENT'S USUAL (Give kind of work don	e during most of working	16b. KIND OF BUSINESS	INDUSTRY		
	Elementary/Secondary (0-12) College (1-4 or 5+) unavailable	life. Do NOT use retired	*				
M	17. FATNER'S NAME (First, Middle, Last)	Homemaker		Own Home			
	unavailable		The second secon	ME (First, Middle, Maiden Surnam 11ab1e	e)		
B	19a. INFORMANT'S NAME (Type/Print)	Table MAILING ADDOG			Zip Code) 20874		
임	Chantha Prak			Route Number, City or Town, State, dge Circle, Go			
	20a. METNOD OF DISPOSITION	ON DI ACEAND DATE OF DISPI	ORITION /Name of	DATE 200 LOCATION	City or Town Rists		
	1 Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	emetery, cremetory or other place	Crematory 6/1	0/05 Alexan	ndria, Virginia		
1 1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	2.	2. NAME AND ADDRESS OF PA	CILITY			
ш	→ 11.			's Sons Funera			
Н	23. PART I. Enter the diseases, or complications that ceus	4	739 Baltimor	e Ave. Hyatts	ville. MD 20781		
	shock, or heart fellure. List only one cause on	each lina.	er the mode of dying, suc	n es cardiec or respiratory	Interval Between		
	IMMEDIATE CAUSE (Final disease or condition	+ +	1 (1:11. 64.	Onset and Death		
	resulting in death) a. DUE TO (OR A)	A CONSEQUENCE OF:	91	liablastoma) one year		
-							
흔	Sequentielly list conditions, If any, leading to immediate	A CONSEQUENCE OF):					
S	CAUSE (Disease or injury						
	thet initiated events DUE TO (OR AS resulting in death) LAST	A CONSEQUENCE OF):					
CERTIFICATION	d						
AL 0	PART II. Other significent conditions contributing to death	but not resulting in that	underlying ceuse given in	Pert i. 24e. WAS AN AUTOPS	SY 24b. WERE AUTOPSY FINDINGS		
	None			PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
MEDIC				TO TES 2 IN NO	OF DEATH?		
2	DID TOBACCO USE CONTRIBUTE TO	CAUSE OF DEA	ATH YES IT NO	ods	TES ZDICALD		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	CAUGE OF DE	26. PLACE OF DEATH (Ch				
Sic	1 YES NO HOSPITAL: 1 Inpetient 2 ER/O	stpetlent 3 DDA	ER: using Home 5 - Realdence	8 Other (Specify)			
🛊	27. MANNER OF DEATH 28e. DATE OF INJUR (Month, Day, Year	Y 28b. TIME OF INJURY	28c. INJURY AT	28d. DESCRIBE NOW INJURY	OCCURED		
ВУ	14 Netural 5 Pending Investigation		1 YES 2 NO	-			
9	3 Suicide 8 Could not be 28e. PLACE OF INJU	RY — At home, farm, street, fe	ictory, office	281. LOCATION (Str. City or Town, State)	iber or Hursi Route Mumber,		
E	4 Nomicide determined	-					
립	29a. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the best of my kn						
COMPL	One) 2 MEDICAL EXAMINER: On the basis of examine	lon and/or investigation, in my	opinion, death occured at the	time, data and place, and due to	o the cause(a) and manner as stated.		
BE C	SIGNATURE AND TITLE OF CERTIFIER	1.1.	29c. LICENSE NUN	ABER 29d. C	DATE SIGNED (Month, Day, Year)		
0 8	Kunton	Internist	. 337	1013 1	June 17 1995		
F	30. NAMELAND ADDRESS OF PERSON WNO COMPLETED CAUSE OF BRUCE M CONGER, MD	DEATH (ITEM 27) (Type, Print)	-1211 0	tuxent Plany	Columbia		
			S LITTLE PE	MAKENT FRANK	, Mary land 21644		
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SI	ALA HA					
	JUN 1933 Am	V					



March permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give stre 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 5104 Oakland Way Camp Springs 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Prince George's Camp Springs 10e. STREET AND NUMBER FUNERAL 5104 Oakland Way 20746 be detached for use as the burial-transit retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? XX YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 XNO Specify: 1 Naver Married 2 Married BY 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Spe Elementary/Secondary (0-12) College (1-4 or 5+) Branch Manager 12 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) 76 BE George William Petty has been signed by the attending physician and completely filled in by the funeral director, page 5 should Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Cora J. Petty 5104 Oakland Way, Camp Springs Раде 6 тау be 9 20a. METHOD OF DISPOSITION

1 M Burlal 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of une 22, 10975 5 20c. LOCATION - City or Town, State cemetery, cremetery, cremetery, cremetery or other place) must Resurrection Cemetery ☐ Donation 5 ☐ Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE CICENSI 22. NAME AND ADDRESS OF FACILITY hours after death. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Dne cause Dn aach lina. IMMEDIATE CAUSE (Final the disease or condition DUETO (OFF AS A CONSCIONECE OFF: resulting in death) traumatic event, executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760 CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate the death certificate be cause. Enter UNDERLYING other 1 CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 Injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL requires that any shows DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO | UNCERTAIN | PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) The Hem certificate h EXAMINER? HOSPITAL OTHER: HOSPITAL OR ATTENDING PHYSICIAN: 1 Inpallant 2 ER/Outpetient 3 DOA ng Home 5 (Desidence 8 - Other (Specify) 4 🗆 No 6 28a. DATE OF INJURY (Month, Day, Year) 27. MANNED OF DEATH with L 28b. TIME OF 28c. INJURY AT WORK? is marked, 1 Netural INJURY M L DIRECTOR: After the hours after death w 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide COMPLETED 8 Could not be 4 Homicide 28 29s. CERTIFIER (Check ant) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. FUNERAL I 2 MEDICAL EXAMINER: On the basis of examin TO THE HOSPITA
TO THE FUNERA
De filed within 7. investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CENTRISES LICENSE NUMBER BE Hegurlo 2 D CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

CERTIFICATE OF DEATH

50

61

IF UNDER 24 HRS

ans

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

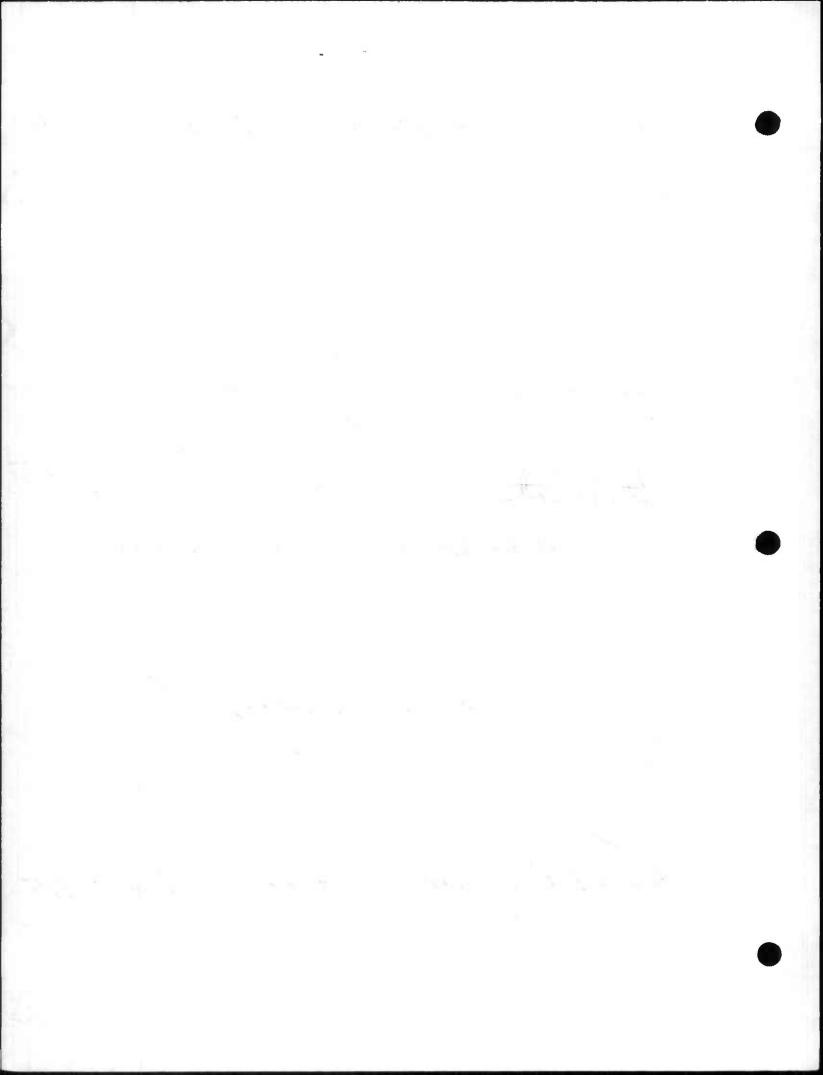
578-42-6826

31. DATE FILED JUN 2 8 1995

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95 20694 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO 2. DATE OF DEATH 3. TIME OF DEATH YEAR 300 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Maryland 10 9c. COUNTY OF DEATH Prince George's 10d. INSIDE CITY 1 TES 2 NO 10g. CITIZEN OF WHAT COUNTRY? United States 14. RACE — American Indian, Black, White, etc. Specify: White 18b. KIND OF BUSINESS/INDUSTRY Banking Ethel Hardini Suthard Md. 20746 Clinton, Maryland Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md20735 Approximate Interval Batwe Onset and Death 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY 1 TYES 2 78-40 OF DEATH? 1 TYES 2 T NO 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29d DATE SIGNED (Month, Day, Year)

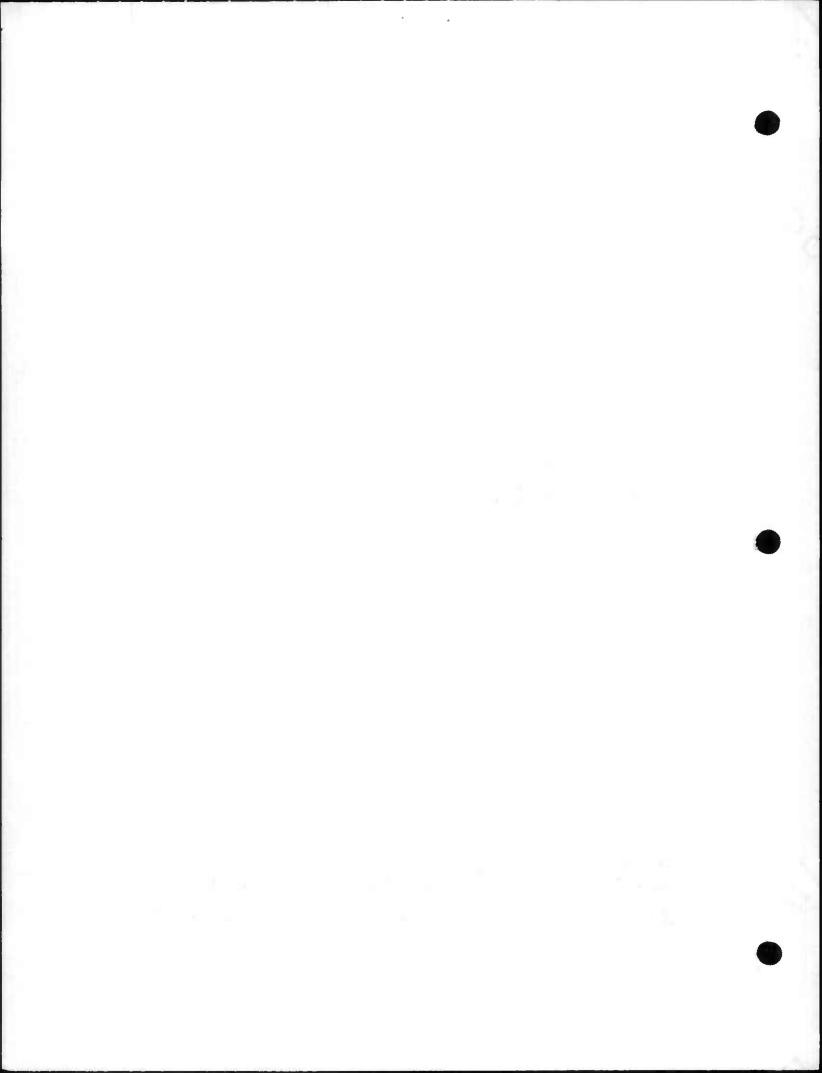


P.O. BOX 68760 DIVISION OF VITAL RECORDS,

STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH een June 24, 5:30 1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign 054-20-3968 1 M 2 X F 66 YRS Sep. 25, 1928 New York Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY TOWN OR LOCATION OF BEATH 9c. COUNTY OF DEATH Laurel Regional Hospital DIRECTOR Laurel Prince George RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Eldersburg Carroll Maryland 1 YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6613 Sweet Air Lane use as the burial-transit 21784 U.S.A. hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-tran 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuben, Mexicen, Puerto Ricen, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 Merried BY Specify: 3 🕅 Widowed 4 🗌 Divorced white 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Sp Grade 12 College (1-4 or 5+) Bookkeeper Building Industry once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) George Hopkins notified at LuLu Unknown BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 21784 LuAnn Davis 6613 Sweet Air Lane Eldersburg, Maryland pe 20a. METHOD OF DISPOSITION
1 Burlal 2 CCremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must Metro Crematory 6/26 Catonsville, Md. 4 Donation 6 Other (Specify) 21 SIGNATURE OF FUNERAL SERVICE LICENSEE medical examiner 22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home P.A. They filled in by the fi 313 Talbott Avenue Laurel, Md. 20707 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heart feliure. List only one cause on each line. interval Batween cremation, or **IMMEDIATE CAUSE (Final** Onset and Daeth the disease or condition completely Acute Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF): minutes resulting in death) traumatic event. that the death certificate be executed wit n and com to burial, c minutes Hypoxemia CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate attending physician prior cause. Enter UNDERLYING Septicemia hours CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST Peripheral Vascular Disease days 0 the atter PART II. Other aignificant conditions contributing to death but not recuiting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? MEDICAL 24a. WAS AN AUTOPSY by th PERFORMED? shows any signed l 1 TYES 2 NO requires 1 | YES 2 | NO t. of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has be Dept. PHYSICIAN: OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate to the State HOSPITAL: 1 YES 2X NO 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28e. DATE OF INJURY 6 the 27. MANNER OF DEATH 28c, INJURY AT WORK? 26b. TIME OF 26d. DESCRIBE HOW INJURY OCCURED this c marked, 1 X Natural 5 Pending BY 1 YES 2 NO Affer 2 Accident 28e. PLACE OF INJURY — At home, ferm, atreet, fectory, office building, etc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) .09 COMPLETED DIRECTOR: A hours after d 6 Could not be 4 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTE DE filed within 72 hours at IMPORTANT: If Item 21 29a. CERTIFIER 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end manner ee stated. THE HOSPITAL C THE FUNERAL D filed within 72 ho nination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end manner se stated. BE 2 DEATH (ITEM 27) (TAR. 521 then 32. REGISTRAR'S SIGNATURE 8 1995 a Davidson Revolate

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

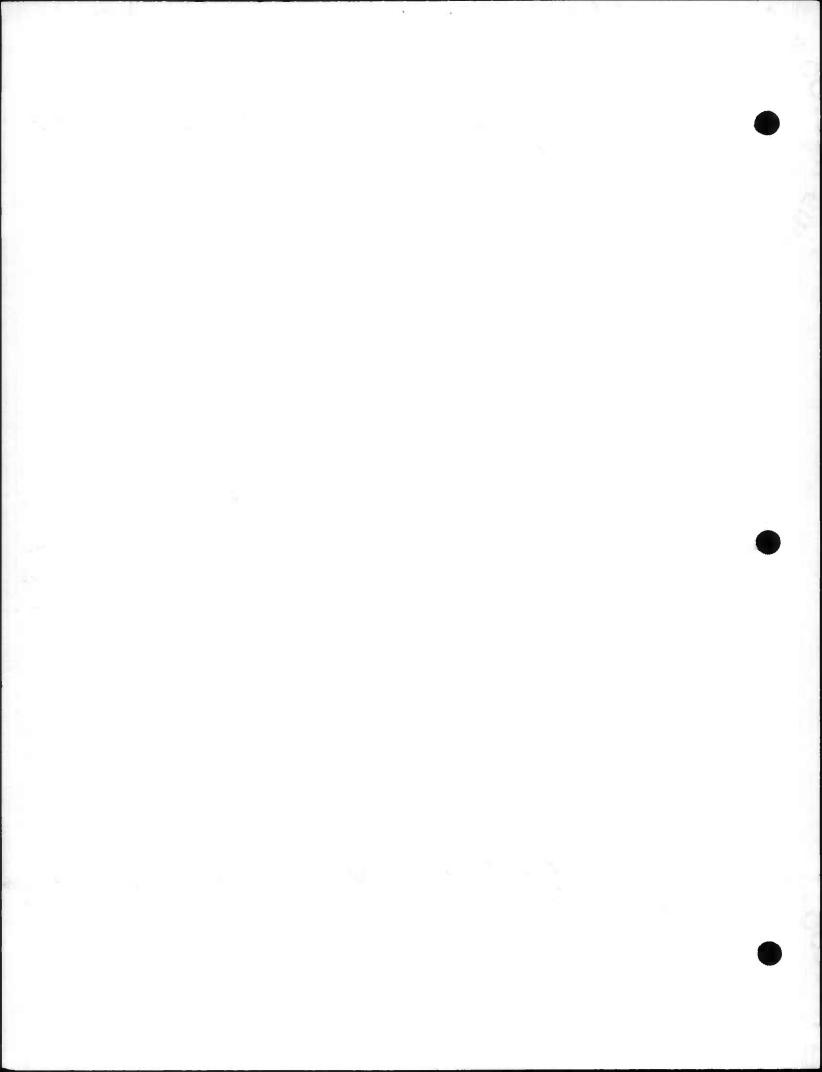
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. A hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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						95	20696		
	1 - FOR STATE OF MA	RYLAND / DEPAI CERTIF	RTMENT OF I	IEALTH AND N	MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last) ANY REAM	an			2. DATE OF DEATH DATE TO TUNE Z	W	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER / 5. SEX 6.	AGE (In yrs. lest birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	- 1	BIRTHPLACE (State or Foreign Country)		
	9a. FACILITY NAME (If not institution, give street and number)	12	9b. CITY, TOWN	OR LOCATION OF DE	Dec 7, 19		Virginia		
TOR	Laurel Regional Hospital		Laurel			Prince George			
REC	10e. STATE 10b. COUNTY	10c. Cl	TY, TOWN OR LOCA	TION			10d. INSIDE CITY		
BY FUNERAL DIRECTOR	Maryland Anne Arundel	La	aurel		1 - YES 2 X NO				
RA	Rt 198 Welch's Trailer Parl	r Tot 22	10	20724	10g. CITIZEN OF WHAT COUNTRY?				
NO.	11. MARITAL STATUS 12. WAS DECEDENT E	VER IN U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	IC ORIGIN? (Specify Yea	USA or No — 1	14. RACE — American Indian, Black, White, etc.		
ВУ Б	1 Never Married 2 X Married FORCES? 1 FYES, GIVE WAR			ecify Cuberi, Mexicar 2 X NO Specify					
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)		S USUAL OCCUPATI		16b. KIND OF BUS	SINESS/INDU			
LET	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT		st or working					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 11 17. FATHER'S NAME (First, Middle, Last) Unknown 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use relited.) Spot Welder 16b. KIND OF BUSINESS/INDUSTRY									
								19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
	1 X Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify)	cemetery, crematory or IVV Hill	other place)		6/30 Laur				
	21. SIGNATURE OF FUNESIAL SETT/ICE LICENSEE	/	22. NAME A	ID ADDRESS OF FAC	eral Home,				
_	· Ch Hay Sully		313 7	albott A	ve. Laurel	, Mar	vland 20707		
	23. PART i. Enter the disasses, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, abock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Fine) Approximate interval Between Oneet and Deeth								
	disease or condition resulting in death) s.	avdiac	arr	151			minutes		
	DUE TO (OI	AS A CONSEQUENCE C	OF):	101/14	m		14.1		
ē	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSCOUENCE OF):								
RTIFICATION	CAUSE, Enter UNDERLYING CAUSE (Disease or injury	A AS A CONSEQUENCE O	Carxi	omyou	athy		2 years		
E	that initiated events resulting in death) LAST	AS A CONSCOUENCE C	r):	- /					
L CE	PART ii. Other significant conditions contributing to de	eth but not resulting	In the underlyin	cause given in I	Part I. 24a. WAS AN	ALITOREY	24b. WERE AUTOPSY FINDINGS		
MEDICAL				, outdo given in	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION DF CAUSE		
ME							OF DEATH?		
AN:	DID TOBACCO USE CONTRIBUTE TO CAUS			UNCERTAIN	12				
SICI,	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Input lant 2 Fi	R/Outpatient 3 DOA	OTHER:						
PHYSICIAN:	27. MANNER OF DEATH 28s. DATE OF IN.	JURY 28b. TIN	ME OF 28c. IN.	e 5 Rasidence (URY AT RK?	28d. DESCRIBE HOW IT	NJURY OCCU	PRED		
ВУ	1 Natural 5 Pending 2 Accident Investigation								
9	3 Suicide 8 Could not be determined 28s. PLACE OF II building, atc	NJURY — At home, farm, . (Specify)	street, factory, offic		28f. LOCATION (Street a City or Town, State)	nd Number o	r Rurel Route Number,		
PLE	29a. CERTIFIER (Check only 1) CERTIFYING PHYSICIAN: To the best of my	knowledge, dasth occur	red at the time, date	and place, and due t	to the cause(a) and man	ner sa stated	1.		
COMPLETED	one) 2 MEDICAL EXAMINER: On the basis of exam								
BE	296. SIGNATURE AND TITLE OF CEDITOR	1	ND	29c. LICENSE NUM	BER 7	29d. DATE	SIGNED (Month, Day Noar)		
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE	OF DEATH (ITEM 27) (Type	Print)	1 575	76		5/11/15		

OMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

32. REGISTRAR'S SIGNATURE

Wha Daviden Randall



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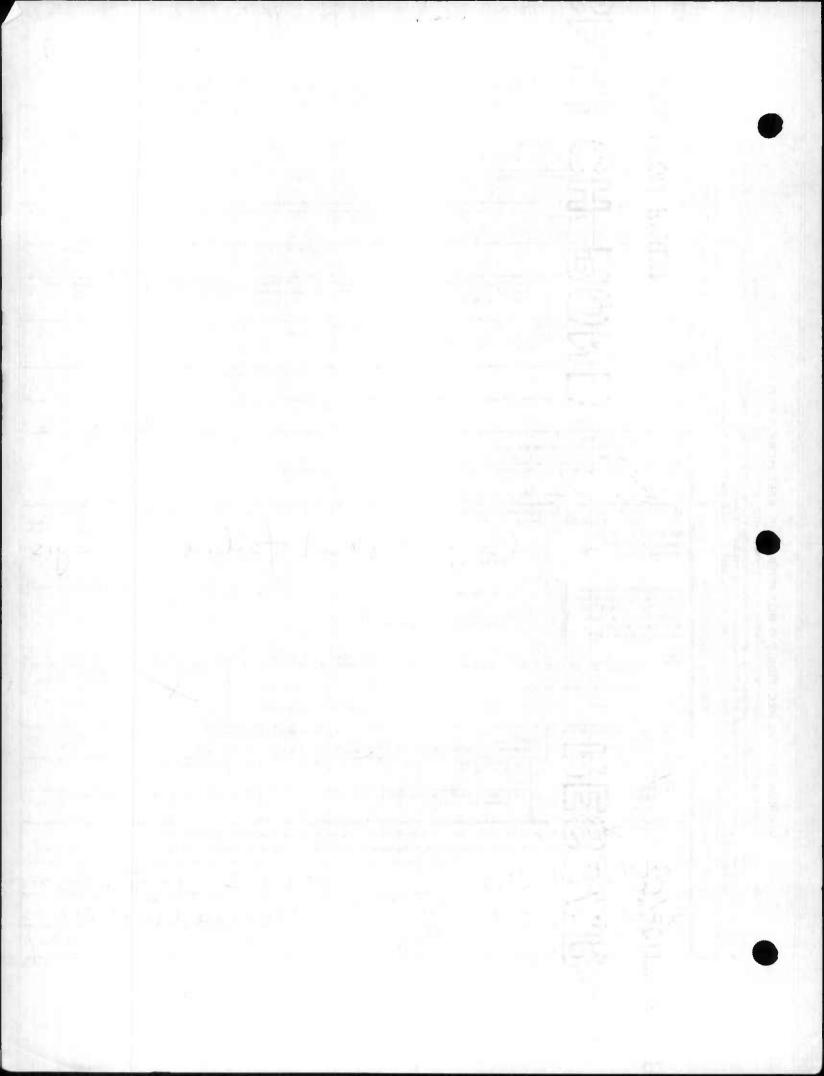
95 20697 1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	Lillian Rothamel									June 2	8, DAY 1995	YEAR	3. TIME OF DEATH 2:25 am	
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. leet b) 1 □ M 2 💢 F 96				t birthday) YRS.	IF UNDER	DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF BIRT (Month, Day,) April	har)	Count	IPLACE (State or Foreign y) New York	
	96, FACILITY NAME (If not in		,			9b. CITY	, TOWN	OR LOCATION	ON OF DE	ATH	9c. COU	NTY OF C	EATH	
6	Mariner Nursing Home					L	aure	1			Pr	ince	George	
EG	10s. STATE	10b. COUNTY			10c. CIT	Y, TOWN (OR LOCAT	TION					10d. INSIDE CITY	
Ha	Maryland	Pri	nce Georg	ge		Laur							LIMITS?	
FUNERAL DIRECTOR	500 5th Str	eet					101. ZIP CODE 20707					10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
B	11. MARITAL STATUS 1 Never Married 2 3 Nidowed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2 X	MED		13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:					- 14. RACE — American Indien, Black, Whita, etc. Specify: White		
COMPLETED		EDENT'S EDUC y highest grade ((Gi	ve kind of Do NOT u	INT'S USUAL OCCUPATION of of work done during most of working (OT use retired.) USEWIFE OWN Home					DUSTRY			
0	17. FATHER'S NAME (First, Mi	iddle, Last)						18. MOTI	NER'S NA	ME (First, Middle, A	Maiden Surname)			
BE C	Bernard Ret	hman								alone				
10	196. INFORMANT'S NAME (7) Lillian Holi	,								Poute Number, City e Silve			Md. 20905	
	Lillian Holmes 13900 Crest Hill Lane Silver Spring, Md 20a. METHOD OF DISPOSITION 1 Surfal 2 Cremetton 3 Removal from State 20b. PLACE AND DATE Compression (Name of Compress													
	22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home P.A.													
	23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, ahock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Daeth Cause or condition of the conditio													
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events b													
E	resulting in death) LAS													
: MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PROPRIED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO													
¥	25. WAS CASE REFERRED TO	O MEDICAL					26. PL	ACE OF D	EATH (Ch	ick only one)				
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outpatient 3 DOA 1 Normaling Home 5 Residence 6 Other (Specify)													
主	27. MANNER OF DEATN	27. MANNER OF DEATN 28s. DATE OF INJURY 28b. T						URY AT		28d. DESCRIBE NOW INJURY OCCURED				
BY F	1 Naturel 5 Pending (Month, Day, Year)						M 1 YES 2 NO							
입	3 Suicide 8 Could not be determined City or Town, State) 266. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 267. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)											Route Number,		
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the bests of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.													
TO BE	sacc	my	MMD	RE OF DEADY (ITE	4.070 (7	D-l-41		72	LYG	42	29d, DA1	Tun	LZB ATS	

Z	Colony	1011		- 1	12999		June CC
0 0	AME AND ADDRESS OF PERSON	WHO POMPLETED CA	USE OF DEATH (ITEM 27) (Typo, Print)	7 (Chem I	2 (.00 110

32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

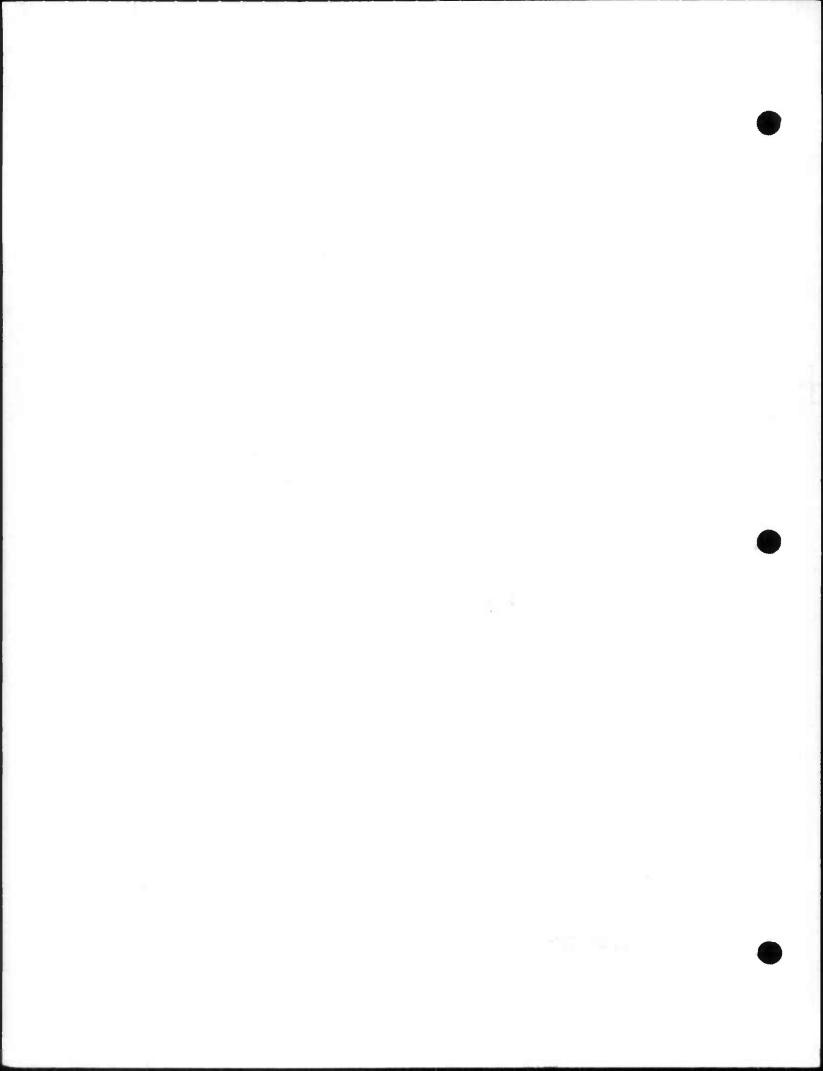


hours after death. Page 6 may be retained by the hospital or attending physician BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
_	REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

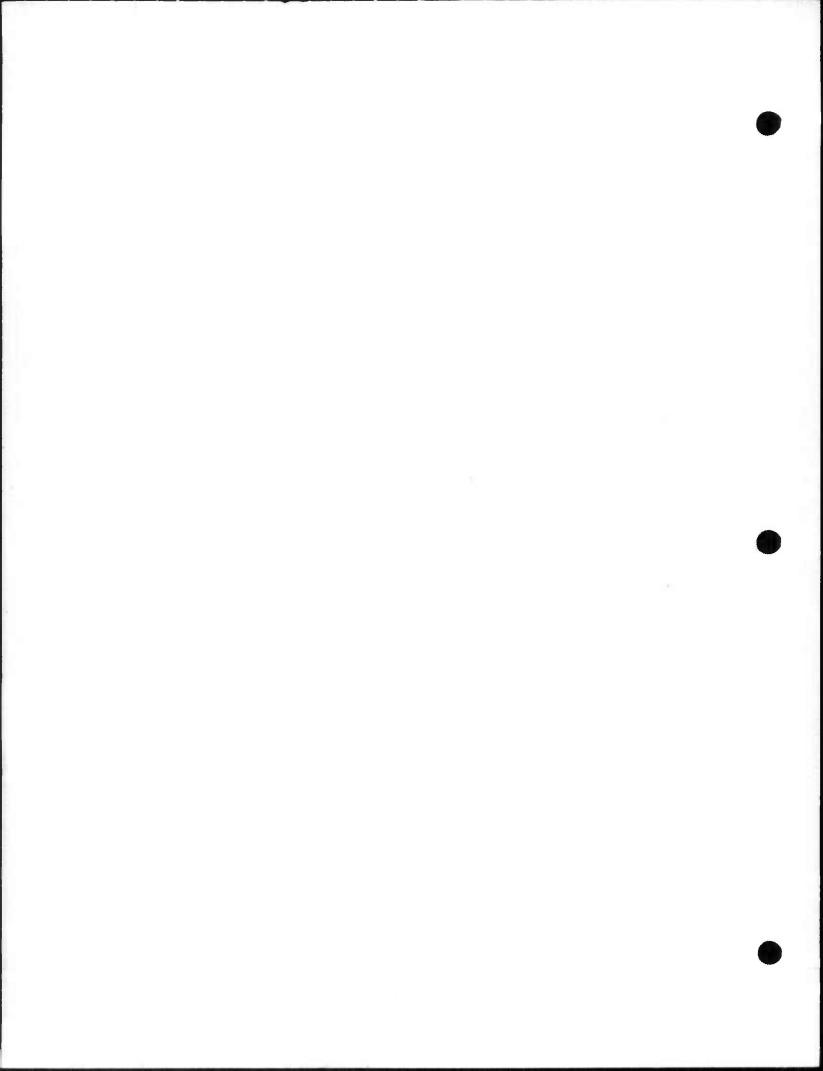
		1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIF				IENTAL HYGIEN REG. NO			
		1. DECEDENT'S NAME (First, Middle, Last) Susanna	NMN REYNAU	ID .				June 24,	1 995	YEAR	3. TIME OF DEATH 8:46 AM
10		4. SOCIAL SECURITY NUMBER 459-24-2963	1 🗆 M 2 🗓 F 9	8 (In yrs. last birthday)	IF UNDER 1	YEAR IF UND	DER 24 HRS.	7. DATE OF BIRTH	1897	8. BIRTH	PLACE (State or Foreign
2, 3 should	OR	50. FACILITY NAME (If not institution, give street and number) Citizens Nursing Home 9b. CITY, TOWN OR LOCATION OF DEATH Frederick 9c. COUNTY OF DEATH Frederick									
-	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	Y	10c, CIT	Y, TOWN OR	LOCATION					10d. INSIDE CITY
mit. Pag			erick	Fre	ederio						LIMITS? XX YES 2 NO
ransit per	FUNERAL	800 Motter Aven				2170	01		U.S	A.	WHAT COUNTRY?
as the burial-transit permit. Pages	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 XXWidowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 Tyes IF YES, GIVE WAR OR	S 2XXNO	11.7	S DECENDENT es, specify Cu YES 2XXN	ıban, Mexican	C ORIGIN? (Specify Yes , Puerto Rican, etc.)	or No-		— American Indian, k, White, atc. nWhite
ed for use	PLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)	College (1-4 or 5+)		USUAL OCC work done dur se retired.) CEEDET	ing most of wor	rking	US GOV			
8 %	BE COMPL	17. FATHER'S NAME (First, Middle, Lest) Michael	SCH	WALM			Anna		SCI	HINI	DLE
page 5 should t be notified	10	Mrs. Sue R. Kolb		5629	Craba	ipple I	ber or Rural Ro Drive,	Frederic	n, state, zip o k, Mai	ry1a	and 21701
mus!		29. METHOD OF DISPOSITION 1 \(\text{D} \) Burial 2 \(\text{Cremation} \) Cremation 3 \(\text{Ren} \) Ren 4 \(\text{Donation} \) Donation 5 \(\text{O} \) Other (Specify)	noval from State 20	DE PLACE AND DATE	of dispositi	etery, J	fune 27,	1995 Fre	cation - c ederic		wn, State Maryland
the funeral director, val.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Allow H 200703 22. NAME AND ADDRESS OF FACILITY Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701									
completely filled in by the rial, cremation, or removal.		23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSCOUENCE OF):									
ending physician and Hygiene prior to bu or other traumati	RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): A S CV D with CIFF DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
been signed by the attraction of Health and Mental shows any Injury,	MEDICAL (PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?									
as been Dept. of 23 sh	AN: N	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WINCERTAIN									
State	<u> </u>	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	HOSPITAL: 1 inpetient 2 ER/Out	26. PLACE OF DEAT	OTHER:		Pasidana 6	Other (Specify)			
fer this certificant with the marked, or	/ PHY	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 26	C. INJURY AT WORK?		28d. DESCRIBE HOW IN	JURY OCCU	RED	
CTOR: After s after deatl	TED BY	2 Accident 3 Suicide 6 Could not be determined determined 4 Homicide City or Rown, State) 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28b. PLACE OF INJURY — At home, farm, street, factory, office City or Rown, State)							oute Number,		
THE FUNERAL DIRECTOR: After this certificate has been signed filed within 72 hours after death with the State Dept. of Health ill of the 28 is marked, or item 23 shows an IPORTANT: If item 28 is marked, or item 23 shows an	COMPLET		ICIAN: To the best of my know ER: On the basis of examination								and manner as stated.
TO THE FUNER be filed within 7 IMPORTANT:	BE (29b. SIGNATURE AND TITLE OF CERTIFIE	R A WAA			29c, LI	ICENSE NUMB	ER C. C. C.			(Month, Day, Year)
₽ & ₹	2	30. NAME AND ADDRESS OF PERSON WITH	O COMPLETED CAUSE OF D	EATH (ITEM 27) (Type,	0. //	CUR	109	a010-	Jur	ne .	12/762
		31. DATE FILED (Month, Day, Year)	32. HEGISTRAMS SIGN	NATURE Parlath	wer.	CUR.	· W	apelov	rue)	<u> 1.Y/</u>	9 4/175



1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

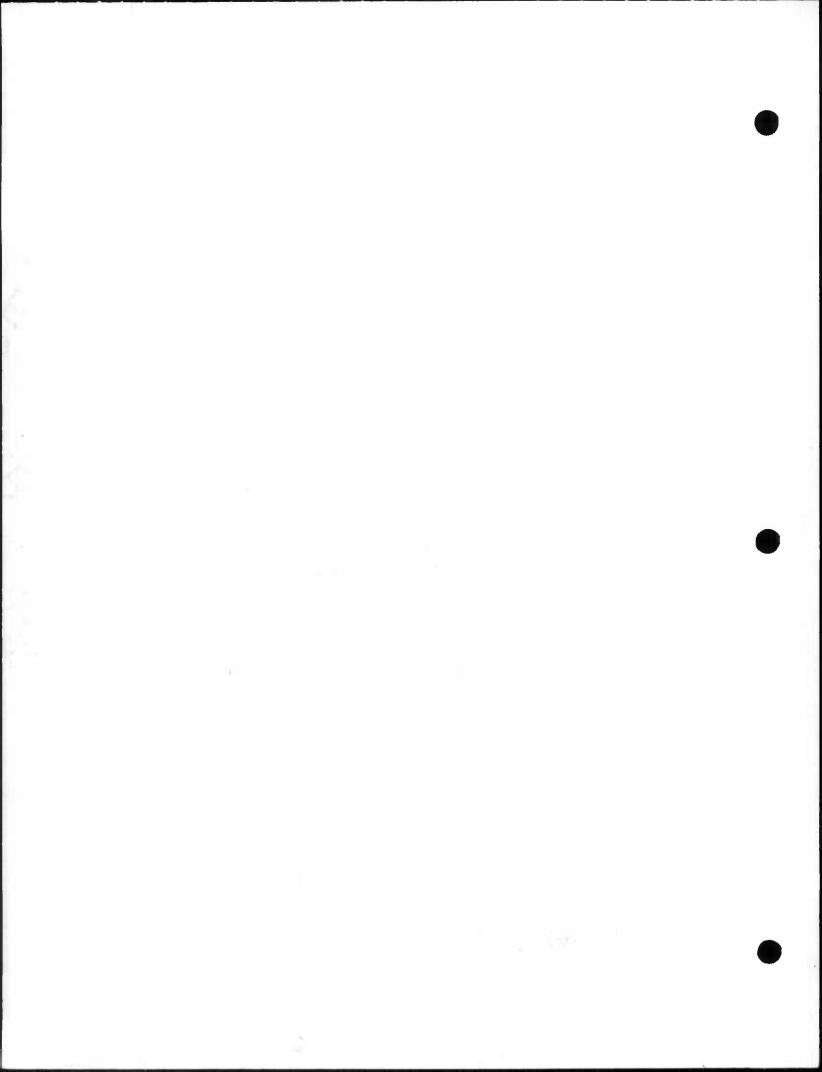
		1. DECEDENT'S NAME (First, Middle, Lest) Elizabe	eth Blanche	RODGERS	S	JI DEATH	2. DATE OF DEATH HONTH 20,		3. TIME OF DEATH 5:05 PM M	
P		4. SOCIAL SECURITY NUMBER 182–16–7848		(In yrs. lest birthday)	IF UNDER 1 YE	AR IF UNDER 24 HRS. WE HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Feb. 22,19	A.1	BIRTHPLACE (State or Foreign Country) ennsylvania	
2, 3 should	CTOR	98. FACILITY NAME (If not institution, give to 5675 Honey Suck1				wn or Location of D derick		9c. COUNTY	of DEATH lerick	
permit. Pages 1,	DIREC	10e. STATE 10b. COUNT Pennsylvania	Y		.1kes B				10d. INSIDE CITY LIMITS? 12XYES 2 NO	
ts.	FUNERAL	10. STREET AND NUMBER 215 High Street				101. ZIP CODE 18702		U.S.	OF WHAT COUNTRY?	
215-0020 attending physician. ise as the burial-transit	B	11. MARITAL STATUS Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I	2 X X10	If ye	DECENDENT OF HISPA s, specify Cuben, Mexico YES 2 XXIO Specifi	,		RACE — American Indian, Black, White, alc. Specify. White	
MARYLAND 21 retained by the hospital or 5 should be detached for u	PLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)			S USUAL OCCU work done during se retired.)	PATION g most of working	166. KIND OF BU		RY	
		17. FATHER'S NAME (First, Middle, Lest) Fred	RC	DDGERS			NAME (First, Middle, Maiden Surname) Inche REESE			
	욘	19a. INFORMANT'S NAME (Type/Print) Mr. Paul Rodgers		19b. MAILING 2641	N. Mor	reet and Number or Rural reland Blvd	Route Number, City or Tow I., Clevela	n, State, Zip Coo ind, Oh	io 44120	
BALTIMORE of death. Page 6 may the funeral director, pa val.		26s_METHOD OF DISPOSITION 1	noval from Stata Ce	ob. PLACE AND DATE ometery, cremetory or Oakland C	enetery	June 24,19	95 Wil	kes Ba	rre, Pa.	
ed within 24 hours aft completely filled in by it ii, cremation, or remo event, the medica		21. SIGNATURE OF FUNERAL SERVICE LIK	Jard.	MO0255	106	East Chur	sford P.A.	Frede	rick, Md. 21701	
		IMMEDIATE CAUSE (Final	Ellat only one cause on a	aach lina.					Interval Batween Onset and Daath	
th certificate be tending physician all Hygiene prior to or other traus	ERTIFIC	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	с	A CONSEQUENCE O						
reduires that the death open signed by the attend to I Health and Mental Health and	AEDIC	PART II. Other significant condition					PERFOR	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
23 ep 3	1 %	DID TOBACCO USE CONT. 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	RIBUTE TO CAUSE (28. PLACE OF DEA			N 🗆 📗			
PHYSICIAL this certification with the right of the control of the	\	1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation	1 ☐ Inpetient 2 ☐ ER/Out 28e. DATE OF INJURY (Month, Day, Year)	28b. TIR	4 Nursing	Home 5 Residence INJURY AT WORK? YES 2 NO	6 Other (Specify) 26d. DE\$CRIBE HOW II	NJURY OCCURE	£D	
OR ATTENDING I OR ATTENDING I DIRECTOR: After hours after death	TED	2 Accident investigation 3 Suicide 6 Could not be delermined	28e. PLACE OF INJUR building, atc. (Spe	Y — At home, lerm, ecily)	street, factory,	office	261. LOCATION (Street a City or Town, State)		urel Route Number,	
보 그 가 도	릴		CIAN: To the best of my know						use(s) and manner as atated,	
TO THE HOSPIT TO THE FUNERA De filed within 7	TO BE (29b. SIGNATURE AND TITLE OF CERTIFIED 30. NAME AND ADDRESS OF PERSON WH	home	EATH (ITEM OR) (I	Orlean	D 14626			e 21, 1995	
	1	Dr. P. Gregory R	ausch MD 501	. West Se	venth :	Street, Fr	ederick, M	arylan	d 21701	
		31. DATE FILED (Month, Day, Year) JUN 2 3 1995	32. REGISTRARIS SIGN	Geor Rendal						



1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

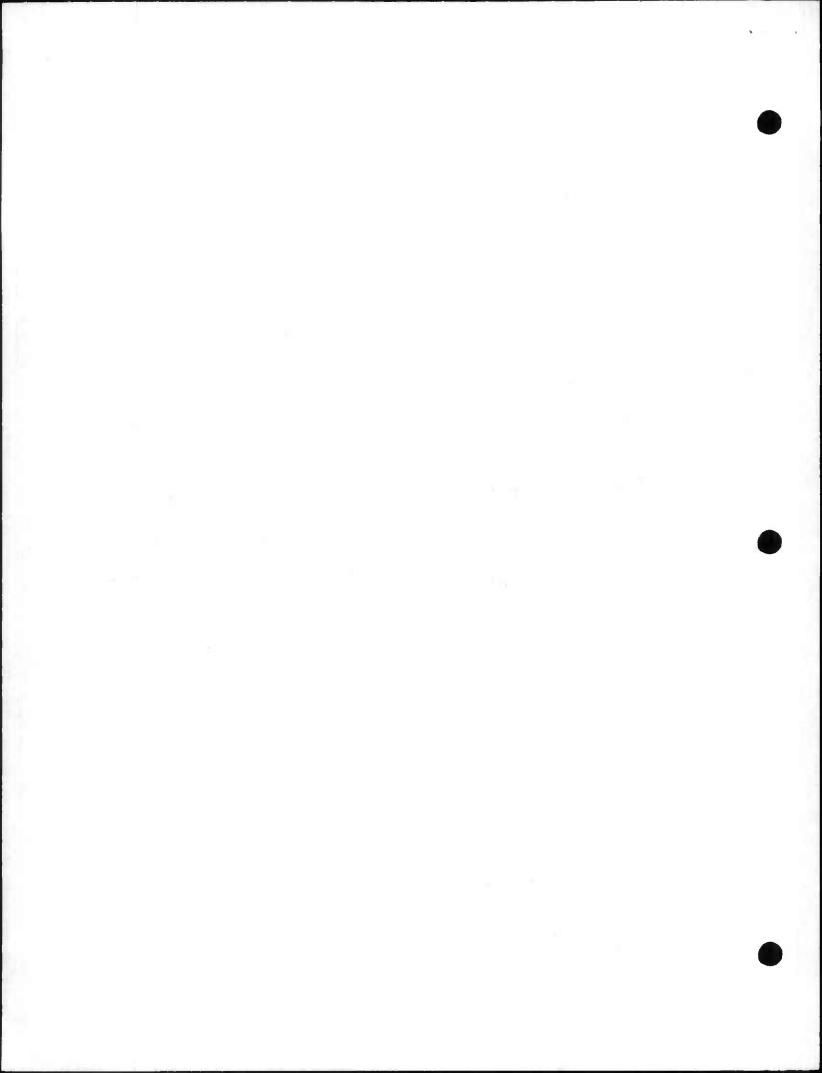
		4 0505051170 11117 551 - 1417 1					TIEG. NO			
		1. DECEDENT'S NAME (First, Middle, Last) Lena M.	Roberts				2. DATE OF DEATH		YEAR	TIME OF DEATN
				yrs. last birthday)	IF UNDER 1 YE		June 19			12:20A M
	1	222 24 2215	111111111111111111111111111111111111111	6 YRS.		AR IF UNDER 24 HRS. WE HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year)		Country)	NCE (State or Foreign
plnonla		9e. FACILITY NAME (If not institution, give street			9h CITY TO	WN OR LOCATION OF D	Apr.10,1		TY OF DEAT	Virginia
en en	E	Carroll County		spital		stminste			rrol	
1, 2,	E	RESIDENCE OF DECEDENT						Cu	1101.	1.
Pages	DIRECTOR	Maryland Mont	gomery		Y, TOWN OR LE			10d. INSIDE LIMITS?		
permit. F					Serman			1 X YES 2 □ NO		
	FUNERAL	13006 Well Hou	so Court			10f. ZIP CODE 20874	1		ZEN OF WHA	
020 physician. burial-transit	뽕		2. WAS DECEDENT EVER IN	LC ABUED	1 40 1400				U.S.	
D20 physic burial		1 Never Merried 2 Married	FORCES? 1 YES	2 XNO	If yes	s, specify Cuben, Mexic	an, Puerto Rican, etc.) Black,			American Indien, hite, etc.
P 2 2	TO BE COMPLETED BY	32 Widowed 4 Divorced	IF YES, GIVE WAN ON DAI	E3	,,,	YES 2 NO Speci	Ny.		Specify:	White
21215 al or attend for use as		15. DECEDENT'S EDUCAT (Specify only highest grade co	TION (moleted)	16a. DECEDENT'S		PATION g most of working	16b. KIND OF BUS	SINESS/INDO	USTRY	
			Cotlege (1-4 or 5+)	Waits	se retired.)	y most or working	Foo	02 b	rvic	
AND the hospit detached once.		12		Walti	. C55				IVIC	-
d de te		17. FATHER'S NAME (First, Middle, Last)					AME (First, Middle, Melden	Surname)		
TARYL stained by the should be stiffed at		Amazariah 190. INFORMANT'S NAME (Type/Print)	Harmon			De1:				
MAR retained 5 should		Dorothy Nines					Route Number, City or Tow			20874
be age			100.0				Court,Ger			
MORE age 6 may director, pag		METHOD OF DISPOSITION Surface 2 Cremetion 3 Remove Dennetion 5 Deter (Specify)	of from State	PLACE AND DATE	ther place)	cans Cem	1		City or Town,	, Maryland
Page 1	- 4	21. BIGHATURE OF FUNERAL SERVICE LICEN	ISEE							
4 9 2 X		Mut L.	Villians)	0111	1 L. Mole	sworth, P	.A.,	Fune	ral Home
							Road, Dam			
5 5		23. PART I. Enter the disesses, or cor shock, or heart fellure. Lie	it only one cause on asc	ch iina.	not anter the	mode of dying, au	ch ss cerdiac or raapi	ratory arre	est,	Approximeta interval Between
5 €		IMMEDIATE CAUSE (Final disesse or condition	Cardiore	enirat	ory 7	rrost				Onset and Death
ted withings. completely fills ial, cremation, event, the		resulting in death) a.	DUE TO (OR AS A	_	_	ILLEBU				Found 12:20
D 5 - 5	_	<u> </u>	Bilatera			cis				AM DEAD. SHALLOW
OX 68 e be execut siclan and c rior to burit traumatic	CATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	ONSEQUENCE O	F):					RESPIRATIONS
ficate be ophysician ne prior to	8	CAUSE (Disease or injury C. ESRD								
	RTIFI	that initisted events resulting in death) LAST	DUE TO (OR AS A						PM	
T = 8 = 0	CER	d.	Large Ri	ght He	emisph	neric CV	A		INTE	RVAL (11:30-M
2 8 8 5 5		PART II. Other significant conditions of	contributing to death but	not resulting	in the underl	lying csuse given in	Part J. 24a. WAS AN	AUTOPSY	24b. WE	RE AUTOPSY FINDINGS
T and and A	MEDICAL	1. IDDM (Insu	lin Depend	lent Di	labete	es Melli	PERFOR		AM	MLABLE PRIOR TO MPLETION OF CAUSE
Sign Sign Sign Sign Sign Sign Sign Sign		2. HTN (Hyper	tension)				T YES 2	NO		DEATH? YES 2 XNO
law requas been of 23 she	ä	DID TOBACCO USE CONTRI		DEATH YE	S NO	UNCERTAL	ND		1	165 2 2 10
N: The law ricate has be State Dept.	CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		. PLACE OF DEA		one)				
SICIAN: The certificate the State	YSICI	1 YES 2 NO	LOSPITAL:	lent 3 🗆 DOA	OTHER:	Nome 5 - Residence	8 Other (Specify)			
PHYSICIAN: The law this certificate has b with the State Dept.	PH	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b, TIM	E OF 28c.	INJURY AT WORK?	28d. DESCRIBE NOW II	NJURY OCCI	URED	
DING PHYS After this of death with s marked	ВУ	1. Natural 5 Pending 2 Accident Investigation			M 1	YES 2 NO				
J 5 4 5 L	ED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY - building, etc. (Specif)	- At home, ferm,	streat, fectory, o	office	281, LOCATION (Street a City or Town, Stete)	nd Number o	or Rural Route	Number,
OR ATTEN DIRECTOR: hours after tom 28 is	LETE									
4 42 =	MPL	29e. CERTIFIER (Check only 1 X CERTIFYING PHYSICIA								
HOSPITAL FUNERAL within 72 t	CON	2 MEDICAL EXAMINER	On the basis of exemination	end/or investigation	n, in my opinio	on, death occured at the	time, date and place, en	d due to the	cense(e) eu	d menner ee stated.
HE HE HE PURE OFTA	шШ	206. SIGNAPURE AND TITLE OF BERTIFIER	. 1. 144	A		29c. LICENSE NU	11/200			nth, Day, Year)
TO THE HOSPIT TO THE FUNERA De filed within 7	0 8		unia m	· /		D 402	201	▶Ju:		9,1995
	- 1	30. NAME AND ADDRESS OF PERSON WHO C	M.D. 150	H (ITEM 27) (Type	Print)	n Ctroo	Mount	A :	2.	1771
					ii Mal	in Street	, Mount	AILA	, Ma	Lyland
		JUN 2 6 1995	32. REGISTRAN'S SIGNAT	CRAP 10						



FOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache the filed within 72 hours after death with the State Debt, of Health and Mental Houlese prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
d within 24 hours after deal	ompletely filled in by the fun I. cremation, or removal.	event, the medical exa-
death certificate be execute	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi be filed within 72 hours after death with the State Deot, of Health and Mental Hydiene prior to burial, cremation, or removal.	ry, or other traumatic
The law requires that the	te has been signed by the ste Dept. of Health and Me	em 23 shows any inju
ATTENDING PHYSICIAN:	ECTOR: After this certifical s after death with the Sta	28 is marked, or ite
TO THE HOSPITAL OR	TO THE FUNERAL DIRE be filed within 72 hours	IMPORTANT: If Item

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.											
	1. DECEDENT'S NAME (First, Middle, Last) John David	Robertson S	r			2. DATE (OF DEATH DA	, , ,	/EAR	TIME OF DEA	тн Ом	
	4. SOCIAL SECURITY NUMBER 5.	. SEX 6. AGE (In	yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE C	DE BURTH	7 10		CE (State or Fi	ioreign	
	213-40-7058 1 9s. FACILITY NAME (If not institution, give etreet	M 2 □ F 5.	3 YRS.				13,19		Md.			
R	Washington Co. Hos		1		agerstow			9c. COUNTY				
CLC	RESIDENCE OF DECEDENT 100. STATE 100. COUNTY	P				/11		was	hing			
DIRECTOR		shington	Toe. City	Middle					1.50	I, INSIDE CITY LIMITS? YES 2 2		
	10e. STREET AND NUMBER			10	. ZIP CODE			10g. CITIZE		COUNTRY?	FNO	
FUNERAL	6419 Zittlestown					21769			Α.			
В	1 MARHIAL STATUS 1 Never Married 2 K Merried 3 Wildowed 4 Divorced	FORCES? 1 YES	WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2X☐ NO FYES, GIVE WAR OR DATES			NIC ORIGIN? an, Puerto R fy:	rto Ricen, etc.) Black, Specify			American Indi hite, etc. CE	len,	
TED	16. DECEDENT'S EDUCATI (Specify only highest grade con		(Give kind of work done during most of working			16b.	KIND OF BUS	INESS/INDUS				
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	4 or 5 +) life. Do NOT use retired.) farmer			l f	arming					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		zacine	-1		iddle, Meiden				-		
BE	John Henry Rober	tson			Depsa							
5	Ruth S. Robertson		6419 Z	ittlest	own Rd.,	Midd	or City or Town	, State, Zip Co	217	769		
	20e. METHOD OF DISPOSITION 1 K Burlei 2 remetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Beaver Creek Cemetery 6/19 Boonsboro, Md.											
	21. SIGNATURE OF FUNERAL SERVICE LICENS	I Rez	ever Cre	22, NAME AL	O ADDRESS OF FA	ACILITY				•	-	
	Jugle D O	work from	G.	31 E.	d B. Tho Main St	., Mi	ddleto	wn, M	d. 2	21769		
	23. PART I. Enter the diseases, or com ahock, or heart failure. List	plications that caused to only one cause on sec	he death. Do no h iins.	ot snter the mo	de of dying, suc	ch ss cardi	sc or respir	atory srres	t,	Approxim Interval B	letween	
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	Acerta	Respo	ratory	Faile	ure				4 W	1 Death	
z	6. (heenis	Obstro	ective	pulu	me	ry {	का म्ब	920	he	20.0	
ATIC	disease or condition resulting in death) a. Acerta lessouratory failure Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING Due to (or as a consequence of):										300	
CERTIFICATION	CAUSE (Disease or injury that initiated events pue to (OR AS A CONSEQUENCE OF): reaulting in death) LAST											
GE	d											
CAL	PART II. Other significant conditions co	ontributing to death but	not resulting in	the underlying	cause given in	Part I.	24s. WAS AN / PERFORI		AWA	RE AUTOPSY FI	TO	
MEDIC						—	1 TYES 2	P NO	OF	MPLETION OF C		
N.	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF	DEATH YES	NO [UNCERTAI	N 🗆			''	YES 2	NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPLTAL:	PLACE OF DEATH	(Check only one)								
HYS	1 YES 2 NO 1	28e. DATE OF INJURY	ent 3 DOA		e 5 ☐ Residence	_	(Specify)	HIBY OCCUR	PED.			
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU		RK?				WLD			
COMPLETED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, etc. (Specify,	At home, ferm, at	reet, fectory, offic		28f. LOCAT City or	TION (Street er Town, State)	nd Number or	Rural Route	Number,		
APLE.	29e. CERTIFIER (Check only one)										- 0	
S	2 MEDICAL EXAMINER: 0	n the basis of examination s	nd/or investigation	, in my opinion, d	eath occured at the	time, date a	ind place, and	due to the c	euse(e) end	menner ee s	tated.	
HE	296. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUI	MBER		29d. DATE S	IGNED (Mor	nth, Day, Year)			
٩	30. NAME AND ADDRESS OF PERSON WHO CO	1 000	H (ITEM 27) (Type, I	Print)	1)211	>	11	- 0	/16	195		
	ABOUL WATER	EFED, MD -	12821	- OAK	Hill	AVE.	HAGA	ERSTO	NW	·wy		
JUN 3 0 1995 32. RESISTRARY SIGNATURE Reviell												



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 17 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
1	1. DECEDENT'S NAME (First, Middle, Leet) Albert Jan	nes Redding				2. DATE OF DEATH	AY YE.	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER	8	n yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	JUNE /	7 9:	BIRTHPLACE (Partners Foreign			
	197-07-5831	1 X M 2 D F 81	YRS.	MONTHS DAYS	HOURS MIN.	5-12-191	4 CF	nesapeake City			
_	9a. FACILITY NAME (If not institution, give at			96. CITY, TOWN	OR LOCATION OF DI	EATH	9c. COUNTY				
DIRECTOR	Union Hospital			Elkton			Cecil				
EC.	10a. STATE 10b. COUNTY	,	10c. CITY	, TOWN OR LOCA	TION		10d. INSIDE CITY				
		Castle	Ne	w Castl	e		LIMITS? 1 YES 25 NO				
RAL	10e. STREET AND NUMBER			26.5	ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?				
FUNERAL	54 Memorial Drive	12. WAS DECEDENT EVER IN	U.S. ARMED		19720	NIC ORIGIN? (Specify Yea	USA	BACP Assets to the			
	1 Never Married 2 Married	FORCES? 1 YES	2 NO	If yes, sp		n, Puarto Rican, etc.)		RACE American Indian, Black, White, atc. Specify: Black			
D BY	3 Widowed 4 Divorced	IN W	II								
TE	18. DECEDENT'S EDUC (Specify only highest grade	completed)	18a. DECEDENT'S (Give kind of w life. Do NOT us	ork done during me	ON ist of working	166. KIND OF BUS	INESS/INDUST	RY			
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	Truck I	100		Trucki	ng				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Meiden					
BE (lding			Vando						
0	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Town					
	Annie Redding 150 E. Main St., Elkton, Maryland 21921										
	20b. PLACE AND DATE OF DISPOSITION 1 St Burlet 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE Of DISPOSITION (Name of commettery, crematory or other pisce) 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State										
	21. SIGNATURE OF FUMERAL SERVICE LICE	DISEE	CELBIIS I	22. NAME A	O ADDRESS OF FA	Congo					
	P (11/1/2	12		P.O.	Box 2593	, Wilm., D					
	23. PART I. Enter the diseases, or co	omplications that caused lat only one cause on as	the death. Do n	ot enter the mo	de of dying, auc	h as cardiec or respi	ratory arrest,				
	IMMEDIATE CAUSE (Final disease or condition	S. M. Mark States		0				Interval Between Onset and Deeth			
	resulting in death)	Couse to	CONSEQUENCE OF	facele_							
7	Chronic obstrace, pullule di Fen.										
OIT	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Character Vision Consequence of the conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PREPER MARCH.										
2	CAUSE (Disease or Injury	Charle	cit of h	ner. (related 1	Howhel)					
CERTIFICATION	that initiated events resulting in death) LAST	Ewe M	CONSEQUENCE OF): C ==={	. 0	0 1		i			
	PART II Other circultural conditions	cardi	Mogath	Y. TRI	THE PARTY	Bull)					
Z Z	PART II. Other algumeent conditions	contributing to deeth bu	it not resulting i	the underlying	g cause given in	FERTOR	MEDI	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE			
MEDIC						1 YES 2	Ano	OF DEATH?			
2	DID TOBACCO USE CONTR	RIBUTE TO CAUSE OF	DEATH YE	S NO	UNCERTAIN	<u> </u>		t Nes 2 No			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOBPITAL:	6. PLACE OF DEAT	OTHER:							
YSI	1 VES 20 NO	1 Inpatient 2 - ER/Outpu		4 - Nursing Hom	e 5 🗆 Residence						
	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	IRY WO	URY AT RK? 'ES 2 NO	28d. DESCRIBE HOW IN	JURY OCCURE	0			
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28s. PLACE OF INJURY	- At home, ferm, st		-1	28f. LOCATION (Street a	nd Number or Ri	ural Route Number			
Ë	4 Homicide determined	building, etc. (Speci	(y)			City or Town, State)					
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my knowle	dge, death occurre	d at the time, date	and place, end due	to the cause(a) and men	ner se stated.				
Ŏ.		R: On the basis of examination						use(a) and manner as stated.			
BE	296. SIGNATURE AND TITLE OF CERTIFIER	ar D			29c. LICENSE NUM		29d. DATE SIG	NED (Month, Day, Year)			
5	30. NAME AND ADDRESS OF PERSON WHO		YU ATPM OF CE		NO 4.8 1	2	- 6	20195			
	Jui Chih	HIU, MD	22	3 W.	st ma	ui ct. 1	HKfor	Md 2194			
	JUN 21 1995	July of Ruther	Rarball								

DHMH-18 Rev 1/89

Page 6 may be retained by the hospital or attending physician. If director, page 5 should be detached for use as the burial-transit BALTIMORE, MARYLAND 21215-0020 hours after death.

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medical examiner

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28 is marked, or item 23 shows any Injury,

BY

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COMPLET

BE 2

2 Acctdent

4 Homicide

29a. CERTIFIER

3 Suicide

the funeral director,

ion, or removal.

6

Pages 1, 2, 3 should

permit.

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 22	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fi	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF GEATH MONTH 06 3. TIME OF DEATH 6 α 10ru 5 Am 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year O 9/0 3 6. AGE (In yrs. last birthday) IF UNDER I YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign (Month, Day. 80-1317 8 1 1 1 2 D F HOURS YRS. 9a. FACILITY NAME (If not institu 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH Magnolia Gardens DIRECTOR Lanham, MD Prince George's RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Prince George's 1 X YES 2 | NO Glenarden FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8110 MLK Jr., Highway #823 20706 USA 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried IF YES, GIVE WAR OR OATES Specify: Black BY 3 Widowed 4 Divorced C 15. DECEDENT'S EDUCATION ecity only highest grade complete 16a. DECEOENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY (So ᆸ College (1-4 or 5+) Elementary/Secondary (0-12) COMPL 12 Travel Consultant 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meide Gradys Lewis James Royall 띪 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 8110 MLK Jr. HWY, Glenarden, MD 20706 Gradys Royall 20a. METHOD OF DISPOSITION
1 N Burial 2 Cramation 3 Ref
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Harmony Memorial Cemetery 6/22/95 Landover, MD ATURE OF FUR 22. NAME AND ADDRESS OF FACILITY Tyrone J. Young Funeral Services 5635 Fads Street, N.E. Wash., DC 23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heart feliure. List only one ceuse on each line. interval Between **IMMEDIATE CAUSE (Fine)** Onset and Death Immunodefficiency Jyudrame diseese or condition_ required resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in deeth) LAST PART ii. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24e. WAS AN AUTOPSY PERFORMED? MEDICAL 1 YES 2 NO 1 YES 2 NO PHYSICIAN:

DID TOBACCO	USE CONTRIBUTE TO CAUSE OF DEATH	YES 🗆 NO 🗆	UNCERTAIN

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER:
4 X Nursing Home 5 Residence 8 Other (Specify) 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA

27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 1 X Natural Investigation

28b. TIME OF INJURY 28s. PLACE OF INJURY — At home, term, street, fectory, office building, stc. (Specify)

28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 YES 2 NO

28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)

1 CERTIFYING PRYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITUE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

2440 M St., N.W., Wash., DC 20037 Valery A. Portnoi M.D.

8 Could not be

32 AREGISTRAR'S DENATURE

BALTIMORE, MARYLAND 21215-0020

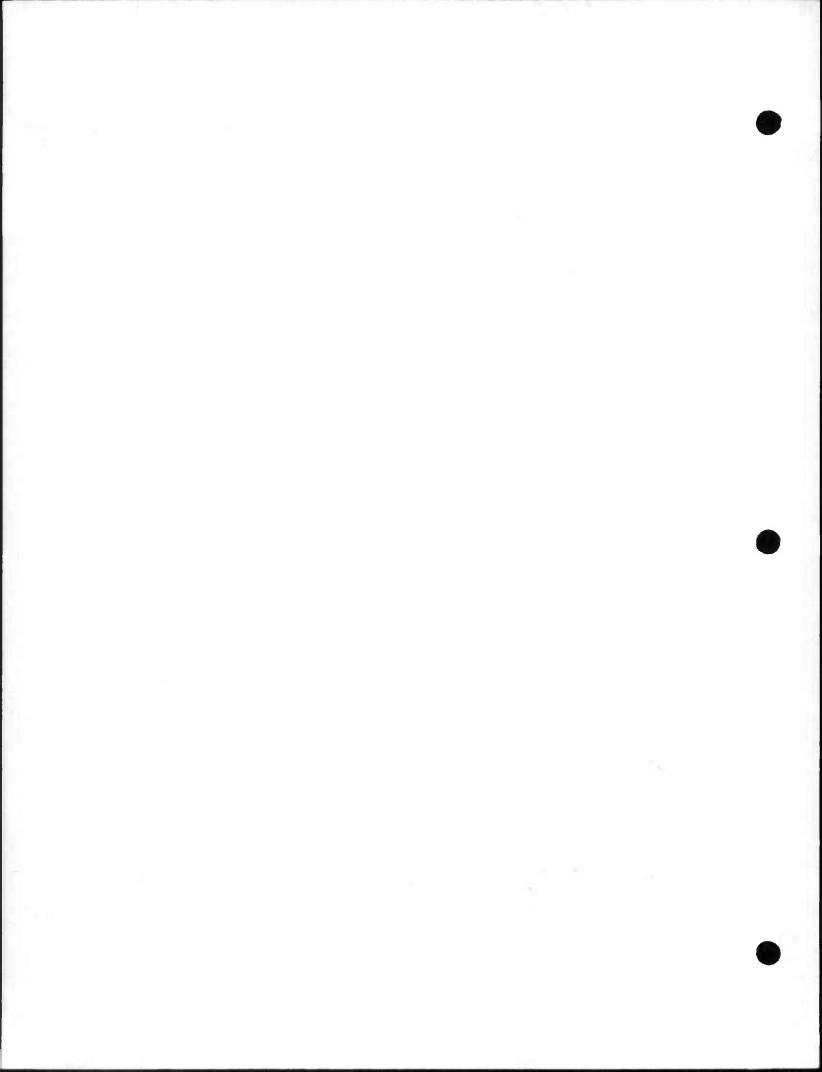
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatte event, the medical examiner must be notified at once.

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFIC	CATE OF	DEATH	REG. NO).			
	1. DECEDENT'S NAME (First, Middle, Last,)		-		2. DATE OF DEATH		3. TIME OF DEATH		
	LIZ	Ε.	RE	AVENELL	1	June /	51/99	10-7		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(in yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH #	10.	BIRTHPLACE (State or Foodige)		
	101-42-3132	1 🗆 M 2 💢 F	46 YRS.	ONTHS DAYS	HOURS MIN.	July 18, 19	48	Bowman, S.C.		
	9a. FACILITY NAME (If not institution, give	street and number)	15	b. CITY, TOWN O	R LOCATION OF DEA		Sc. COUNTY			
OR	Prince George's	Hospital		Chev	verly		Prin	ce George's		
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	TV								
DIRECTOR		rince George		TOWN OR LOCAT			10d. INSIDE CITY LIMITS?			
	10a. STREET AND NUMBER	Tince George	S		zıp cope		Lacation	1 🖺 YES 2 🗌 NO		
FUNERAL	6426 Tay1	or Pond		101.	2073	7		OF WHAT COUNTRY?		
Ž	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS DEC		C ORIGIN? (Specify Ye		ed States		
	1 Never Married 2 Married	FORCES? 1 YES	2 XNO	If yes, spe	cify Cuban, Maxican, 2 XNO Specify:	Puerto Rican, atc.)		. RACE — American Indian, Black, White, atc. Specify:		
В	3 Widowed 4 Divorced			1	* Nice obscury.			Black		
COMPLETED	15, DECEDENT'S EDI (Specify only highest grad	UCATION le completed)	16a. DECEDENT'S US (Give kind of wor	BUAL OCCUPATION done during mos retired.)	N it of working	16b. KIND OF BU	SINESS/INDUS	TRY		
۳	Elementary/Secondary (0-12)	College (1-4 or 5 +)								
¥	12th		D ₁	river			Priva	te		
	17. FATHER'S NAME (First, Middle, Last)					E (First, Middle, Maiden				
BE	Ruben G1 19a. INFORMANT'S NAME (Type/Print)	.over	405 11411 1140 4			Nancy Was				
일	Sam Johnson					oute Number, City or Tox				
	20a. METHOD OF DISPOSITION	20	b. PLACE AND DATE OF			verdale,		737		
	1 Burial 2 Cremation 3 Rar 4 Donation 5 Other (Specify)	moval from State Car	metery, crematory or othe	r place)						
1	21. SIGNATURE OF UNERAL SERVICE LICENSEE Harmony Memorial Park 6/20/95 Landover, Md 22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home									
	NO. T	< to . +	111	4001	Ronning P			D.C. 20019		
\vdash	23. PART I Enter the diseases, or	Man	1111				-			
	immediate cause (Final disease or condition resulting in death)	. LIST ONLY ONE CAUSE ON 6	A CONSEQUENCE OF):					Internal Detuces		
N N	Sequentially list conditions b.									
CERTIFICATION	If any, leeding to immediate cause. Enter UNDERLYING									
윤	CAUSE (Disease or injury thet initieted events	c. DUE TO (OR AS	A CONSEQUENCE OF):							
E	recuiting in death) LAST	4								
	DART II OU II III	u				1000000				
DICAL	PART II. Other significent condition	ne contributing to deeth t	but not resulting in	the underlying	cause given in P	art I. 24s. WAS AN PERFO		AVAILABLE PRIOR TO		
ă	A	770		<u></u>		1 TYES	110	COMPLETION OF CAUSE DF DEATH?		
ME	DID FOR A CCO HEE CONT			5 5		_		1 TES 2 NO		
AN	DID TOBACCO USE CONT 25. WAS CASE DEFERRED TO MEDICAL	KIBUTE TO CAUSE C	25 PLACE OF DEATH		UNCERTAIN					
SICIAN:	EXAMINETY	HOSPITAL:		THER:						
PHYS	1 VES NO 27. MANNER OF CEATH	1 ☐ Inpetient 2 ☐ ER/Out	patient 3 L DOA 4		5 Residence 6		N. II. II. O. O. O. I.			
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR	M 1 N		28d. DESCRIBE HOW	NJUHY OCCUR	EO		
0	3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJURY building, atc. (Spe	Y — At home, farm, stre	at, factory, office		28f. LOCATION (Street City or Town, State)	and Number or	Rural Route Number,		
COMPLET	29a. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the beat of my know	viedge, death occurred	at the time date	and place and due to	the revenies and	nner ee et-t			
NO N		ER: On the basis of examination						Ruse(s) and manner as stated.		
ш	296. SIGNATURE AND TITLE OF CERTIFIE		11.72		LICENSE NUMB			GNED (Month, Day Jaur)		
9	Mugners /	· Today	y Mes	d	4312	30	Jum	16,1998		
	HUBOS LA P. K.	O LIGHTLETED CAUSE OF DE	TH (ITEM 27) (Type, Pr	9 Kay	pum (IF.Cp	m. Y	W714		
li	31. DATE FILED (Month, Day, Year)	32 PROISTNAM'S SIGN	NATURE	L		17		- 00//-		
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

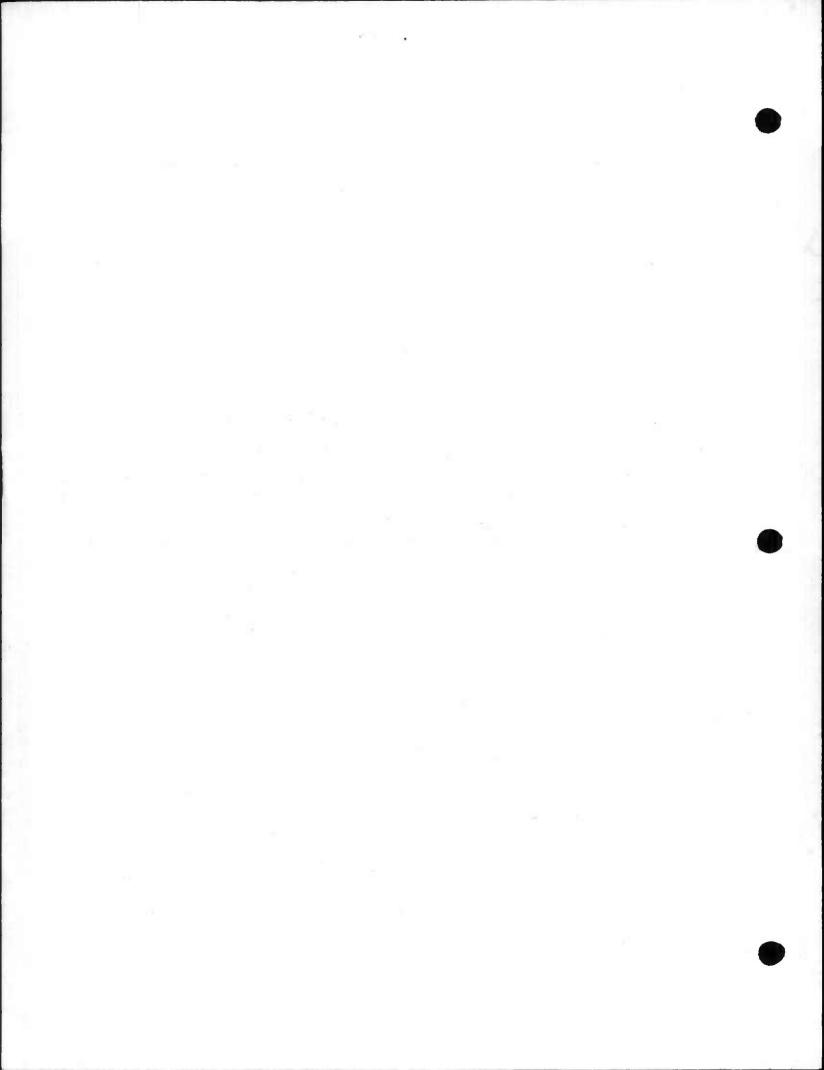
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND N	MENTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTMI CERTIFICA	ENT OF H	EALTH AND	MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH			
	Mary Margaret	Rock				6 11	1995	12:40 A M			
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In yr		NDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8,	BIRTHPLACE (State or Foreign Country)			
	319-30-0931	1 □ M 2 X F 92	YRS. MONT	HS DAYS	HOURS MIN.			ashington.DC			
~	9a. FACILITY NAME (If not institution, give stre	net and number)	9b.	CITY, TOWN O	R LOCATION OF DE	ATH	9c. COUNTY				
DIRECTOR	Villa Rosa Nursing	Home	M:	itche1	lville		Princ	ce Georges			
EC	10a. STATE 10b. COUNTY		10c. CITY, TOV	VN OR LOCAT	ION			10d, INSIDE CITY			
PIG	Maryland Prince	Georges Co.	Mitch	11vi1	10			LIMITS?			
AL	10e. STREET AND NUMBER	OCOLECO CO.	THECH		ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?			
FUNERAL	3800 Lottsford Vis	ta Road		2	0716		USA				
J.	11. MARITAL STATUS 1)XX Never Married 2 Married	12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2		13. WAS DEC	ENDENT OF HISPAN	RACE — American Indian, Black, White, etc.					
ВУ	3 Wildowed 4 Divorced	TE VEO ONE WILL ON DATES						Specify:			
	15. DECEDENT'S EDUCA	ITION 1 160	. DECEDENT'S USUA	LOCCUPATIO	iN .	16b. KIND OF BUS		White			
ETE	(Specify only highest grade or Elementary/Secondary (0-12)	ompleted) College (1-4 or 5+)	(Give kind of work di life. Do NOT use retin	one during mos	st of working	IND. KIND OF BOS	NINE 33/INDUS	INT			
1PL	12		ibrarian			Library	of Co				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Malden		Miless			
BE (James F. Rock				Mary A.	Smith					
2	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDR	RESS (Street a	nd Number or Rural I	Route Number, City or Town	n, State, Zip Coo	cle)			
	Jesse L. Paredes 4420 N 18th St, Arlington, VA 22207										
	20a. METHOD OF DISPOSITION 1 Date 20c. LOCATION - City or Town, State 4 Donation 8 Other (Specify) Congressional Cemetery 6/20 Washington, DC										
	21. SIGNATURE OF FUNERAL SERVICE LICE		ressiona		tery D ADDRESS OF FA	6/20 Was	hingto	on, DC			
	11/11	21 1 0		M	II			22046			
_	Willi A.	Halyal		1/1489	HYF.H.	1102 W.B	PONOS	i. FAllschurch			
	23. PART i. Entar tha diseasas, or co- ahock, or heart failure. Li	mplications that caused the et only one cause on each	a death. Do not ar Ilna.	ntar tha mod	da of dying, suci	h aa cardlac or respi	retory arrest	, Approximata interval Between			
	IMMEDIATE CAUSE (Final disease or condition	Sc. 15	- ()	L. M. PA	mani			Onset and Death			
	DUE TO (OR AS A CONSEQUENCE OF);										
_	To be discher										
⊵	Sequentially list conditions, if any, leading to immediate										
3	CAUSE (Disease or Injury										
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A CON	NEEQUENCE OF):	04.	1 6	7 0					
H	d.	Lines	arrive	Her	ut of	cerles					
AL	PART II. Other algnificant conditions	contributing to death but n	ot reaulting in the	undarlying	cause given in			24b. WERE AUTOPSY FINDINGS			
						PERFOR 1 YES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE			
ME							Q5	OF DEATH?			
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF D	EATH YES	NO 🗵	UNCERTAIN	1 🗆					
CiA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. P	PLACE OF DEATH (Ch	eck only one)							
YSI	1 TYES 2 NO	I Inpatient 2 I ER/Outpatien	H 3 DOA		5 Residence	8 Other (Specify)					
	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJL WOR	RK7	28d. DESCRIBE HOW IP	JURY OCCUR	ED			
B	Accident Investigation	26s. PLACE OF INJURY — A	It home from street		ES 2 NO	201 1 2 2 1 2 2 1 2 2 2 2 2 2 2 2 2 2 2		41			
8	3 Suicide 8 Could not be determined	building, atc. (Specify)	tt riome, tarm, street,	ractory, onice		281. LOCATION (Street a City or Town, State)	nd Number or F	Rural Route Number,			
COMPLETED	29a. CERTIFIER										
MP		AN: To the best of my knowledge									
	The time and the state of the s										
H	296. SIGNATURE AND TITLE OF CERTIFIER WILL WILL SIGNATURE AND TITLE OF CERTIFIER WILL WILL SIGNATURE AND TITLE OF CERTIFIER WILL WILL SIGNATURE AND TITLE OF CERTIFIER WILL SIGNATURE AN					IBER		GNED (Month, Day, Year)			
2	30 NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	(ITEM 27) (Time Print)		יוצונו) 0		11195			
	CIRO A. MOK	TUNER WID	. 1300	were	autile.	laue-la	aude	over wo			
	31. DATE FILED (Month, Day, Vear) 32. REGISTRAR'S SIGNATURE 32. REGISTRAR'S SIGNATURE										

		1 - FOR STATE REGISTRAR	STATE OF MARYLA		TMENT OF H		MENTAI	HYGIEI				
2		1. DECEDENT'S NAME (First, Middle, Last)	illand	Rigs	rdi		2. DATE			YEAR	TIME OF	
5			. SEX 6. AGE (in	yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		OF BIRTH		BIRTHPL	ACE (State	or Foreign
		213 10 3/02	₩ 2 □ F 78	YRS.	MONTHS DAYS	HOURS MIN.		12,	1917 W	Country)		
pinous	-	9a. FACILITY NAME (If not institution, give stree			9b. CITY, TOWN	OR LOCATION OF D			9c. COUNT			<u> </u>
1. 2. 3	CTOR	Harford Memorial H	ospital		Havre	e de Grad	ce		На	rfor	d	
Pages	DIRE	10a. STATE 10b. COUNTY		10c. CITY	, TOWN OR LOCAT	TION				10	d. INSIDE	CITY
permit.		Maryland Ha	rford		Street						YES 2	
sit pe	FUNERAL	3121 Old Scarboro	Rd		101	21154	1		10g. CITIZE			N7
UZU physician. burial-transit	S		2. WAS DECEOENT EVER IN U	J.S. ARMED	13. WAS DEC	ENDENT OF HISPAI		? (Specify Ye	s or No — 1-	US.	American	Indian.
	BY F	1 Never Married 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 YES			ecify Cuben, Mexics 2 NO Specif		lican, etc.)			/hite, etc.	
- D 10		15. DECEDENT'S EDUCAT	10N								Whit	:e
	ETED	(Specify only highest grade cor	mpleted) College (1-4 or 5+)	(Give kind of w life. Do NOT use	USUAL OCCUPATION Fork done during most retired.)	ost of working	16b,	KIND OF BL	SINESS/INDUS	TRY		
	APL	0	conege (I-4 or 5+)	Disa	abled							
the hospit a detached		17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, A	liddle, Msider	Sumame)			
■		Alexander Ric			Bessie		Sha					
retained 5 should notified	2	190. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street end Number or Rural Route Number. City or Town, State, Zip Code) 3121 Old Scarboro Rd., Street, Md. 21154								
6 may be ctor, page		Charles Rigsby 20s. METHOD OF DISPOSITION	20h Pl		JLC SCAY		St		Md. 2		Card	
		1 X Buriel 2 Cremetion 3 Remova 4 Donation 5 Other (Specify)	from State cemete	ery, crematory or off			7⊢95		ublin,			ł
. Page ral dire		21. SIGNATURE OF FUNERAL SERVICE LICEN			22. NAME AN	ID ADDRESS OF FA	CILITY					
death. Page tuneral di		* Alesha II	Muelle			l K. McCc Okesbury						
hours after of in by the or removal.	П	23. PART I. Enter the diseases, or con	plications that caused ti	he death. Do no	ot enter the mo	de of dying, suc	h aa card	ADII	liquon,	Ma.		ximate
D or it		ahock, or heart fellure. Lie IMMEDIATE CAUSE (Finel	t only one cause on eaci	h line.								and Death
		disease or condition resulting in death) a	DUE TO (OR AS A CO	2 My	ocard	eral I	ufa	relu	no		114	A
B 0 5	_		DUE TO (OR AS A CO	ONSEQUENCE OF):		0					
e be executed sician and comitor to burial, traumatic ev	FICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CO	ONSEQUENCE OF):							
ficate be physician ne prior to	8	cause. Enter UNDERLYING CAUSE (Disease or Injury									!	
	RTIFI	that initiated events DUE TO (OR AS A CONSEQUENCE OF): reaulting in deeth) LAST										
4 5 5 6	L III	d										
E Me e		PART II. Other algnificent conditions of	ontributing to death but	not resulting in	the underlying	ceuse given in	Part I.	24a. WAS AN				SY FINDINGS
uires that the signed by the Health and boxs any in	EDIC						_	1 TES		CC	MPLETION DEATH?	
w requires been sign or. of Healt							_			11	YES 2	□ NO
has b	SICIAN:	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH		UNCERTAIN	4 🗆					
E 88 E	SICI	EXAMINER?	OSPITAL: Inpatient 2 ER/Outpatie		OTHER:	District	a 🗆 au	40 41				
PHYSICIAN: this certifica with the Sta	РНҮ	27. MANNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year)	26b. TIME	OF 28c. INJ				INJURY OCCUI	RED		
	BY F	1 Natural 5 Pending 2 Accident Investigation	(MONTH, Day, 16at)	ULMI		RK? ZES 2 NO						
N A P S	ED	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, etc. (Specify)	At home, farm, st	reet, factory, office		281. LOCA City o	TION (Street Town, State	end Number or	Rural Rout	Number,	
DIRECTOR PATE POUR STEEMS AFTER THE STEEMS AT THE STEEMS AFTER THE STEEMS AFTER THE STEEMS AFTER THE STEEMS AFTER THE STEEMS AFTER THE STEEMS AFTER THE STEEMS AFTER THE STEEMS AFTER THE STEEMS AFTER THE STEEMS AFTER THE STEEMS AFTER THE STEEMS AFTER THE STEEMS AFTER THE STEEMS AFTER THE STEEMS AFTER THE STEEMS AFTER THE STEEMS AFTER THE STEEMS AFTER THE STEEMS AT THE STEEMS AFTER THE STEEMS AFTER THE STEEMS AFTER THE STEEMS AT THE STEEMS AFTER THE STEEMS AT THE ST	L	AL CERTIFIES										
로 로 전 ==	COMPL	(Check only CERTIFYING PHYSICIAL	N: To the best of my knowledge.									
HOSPITAL FUNERAL WITHIN 72 TANT: IF		29b. SGNATURE AND TITLE OF CERTIFIER	The business of examinations of	nwor investigation	, in my opinion, o			and place, as				
물 물을 원	BE	Whiten AM				D 326	OP		29d. DATE S	DII M	A Day	ber)
668₹	일	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEATH	(ITEM 27). (Type, I	Print)	- 3.		0		go i lor	~	
			rutian is	D 703	Revol	Culion S	++	avre	Del	rau	Ms;	21078
		31. DATE ALED (Month, Day, Year)	37. DEGRETARE SIGNAL	RELATI				-				
	ı 11		1									



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygher prior to burial, cernation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event. the medical examinar must he matified at marked, or Item 28 shows any Injury, or other traumatic event.

30. NAME AND ADDRESS OF PERSON.

Slynon Medical

31. DATE FILED (Month, Day, Year)

JUN 2 6 1995

Towner by
WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

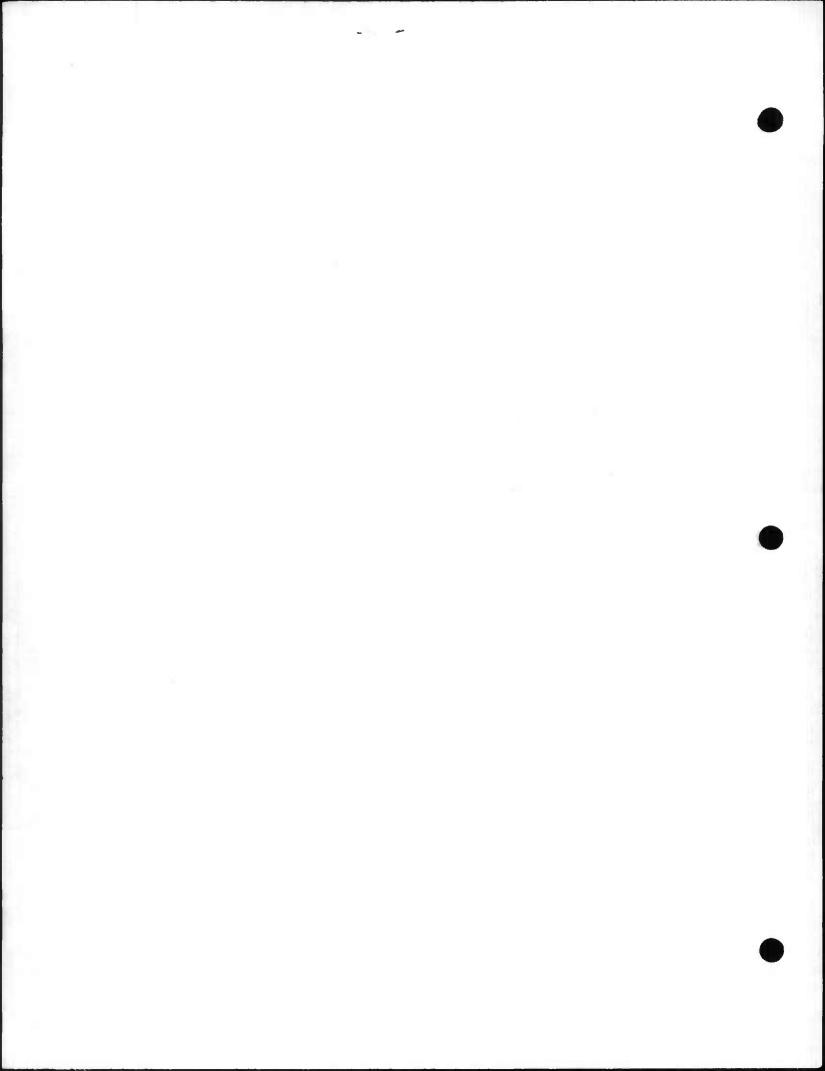
A RAKSO Sul'an

REGISTRAD'S SIGNATURE

							95	20707			
	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ND / DEPARTM			MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	AY Y	3. TIME OF DEATH			
	Daniel Simpso					June 21	1995				
	4. SOCIAL SECURITY NUMBER		MO	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)			
	428-62-6155	XIXM 2 □ F 60	YRS.			April 7,	1935	Mississippi			
000	Se. FACILITY NAME (If not institution, give str		,	OR LOCATION OF DE	ATH	9c. COUNTY	Y OF DEATH				
10	6847 Mathews R	F	Byrans	Road		Char	les				
DIRECTOR	10e. STATE 10b. COUNTY	10c. CITY, TO	OWN OR LOCA	TION			10d. INSIDE CITY				
	Maryland Char	les	Bry	ans I	Road			1 WES 2 NO			
FUNERAL	10e. STREET AND NUMBER				f. ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?			
	6847 Mathews R	oad			20616		U.	S.A.			
15	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U FORCES? 1XXYES	S. ARMED	13. WAS DE	CENDENT OF HISPAN	IIC ORIGIN? (Specify Yen, Puerto Rican, etc.)	or No- 14	. RACE — American Indian, Black, White, etc.			
BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	8		2 -NO Specify			Specify:				
	15. DECEDENT'S EDUC	1954-1962	6a. DECEDENT'S USU	141 000010171	001	Lau man an an		White			
	(Specify only highest grade of	completed)	(Give kind of work life. Do NOT use re	done during m	ost of working	16b. KIND OF BU	SINESS/INDUS	TRY			
1	Elementary/Secondary (0-12)	College (1-4 or 5+)	Meat Cu	ttor		Store					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		near ca	OUCI	18. MOTHER'S NA	ME (First, Middle, Melden					
	Simpson Hope R				Lucille		or				
BE (190. INFORMANT'S NAME (Type/Print)		196. MAILING AD	DRESS (Street		Toute Number, City or Tow	-				
2	Gregory S. Rab	orn	#3 Ga	ring	Ct., In	dian Hea	d. Md	20640			
	20s, METHOD OF DISPOSITION	20b. PI	LACE AND DATE OF D	ISPOSITION (N				y or Town, State			
	4 Donation 5 Other (Specify)		ory, crematory or other possible Ce	meter	v June	25.1995	Osyka	, Mississipp			
	21. SIGNATURE OF FUNERAL SERVICE LOCAL	NSEE //		22. NAME A	ND ADDRESS OF FAC	HITY					
	Mullh	Man N	100668			neral Ho					
	23. PART I. Enter the diseases, or co	omplications that aused the	he death Do not	enter the mo	de of dving, suci	TYMONE R	C., I	ndian Head, M			
	snock/ or heart failure. List only one-cause on each line.										
		Carlingoulon		D. T.	1 . 80 . 2	1 m	0. 10	Oneat and Death			
	resulting in death)	Carclio pulm	ONSEQUENCE OF):	way pr	coron of	to mysca	which or	yeldien			
z	- Hypertracio Confinitar on Dram										
RTIFICATION	Sequentially list conditions, if any, leading to immediate	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events Due 10 (Orlas a consequence of): Due 10 (Orlas a consequence of):									
8	CAUSE (Disease or Injury	thistory of ?	nyocard	ial is	faction	L					
E											
	resulting in death) LAST	Emphipen	a								
	PART II. Other aignificent conditions	contributing to deeth but	not resulting in ti	ne undariyin	g cause given in	Part I. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS			
MEDICAL			_			PERFOR	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
<u></u>						1 YES 2	NO NO	OF DEATH?			
	DID TOBACCO USE CONTR	IRUTE TO CAUSE OF	DEATH YES	II NO F	UNCERTAIN			1 NES 2 NO			
¥	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH (C		J OIACEKIAII						
Sic		HOSPITAL: 1 Inpetient 2 ER/Outpetie		HER:	ne 5 🗆 Residence	8 Other (Specific)					
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME OF	28c. IN.	IURY AT	28d. DESCRIBE HOW I	NJURY OCCUP	RED			
ВУР	1 Netural 5 Pending	(Month, Day, Year)		PRK? YES 2 NO							
	2 Accident Investigation 3 Suicide 6 Could not be	28s. PLACE OF INJURY	At home, farm, stree	t, factory, offic	•	281. LOCATION (Street		Rural Route Number,			
TED	4 Homicide determined	building, atc. (Specify)		City or Town, State)							
COMPLET	290. CERTIFIER 1 CERTIFYING PHYSIC	to the ceuse(e) end mai	mer ee statud								
)ME		On the basis of examination er						ause(s) and manner as stated.			
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c, LICENSE NUM						
BE	De Comer For	San Da			D1951			IGNED (Month, Day, Year) 123 / 95			
2	In was acres to	mangy			01191	U	61	0.2(7)			

mf. 20640

DHMH-18 Rev 1/89



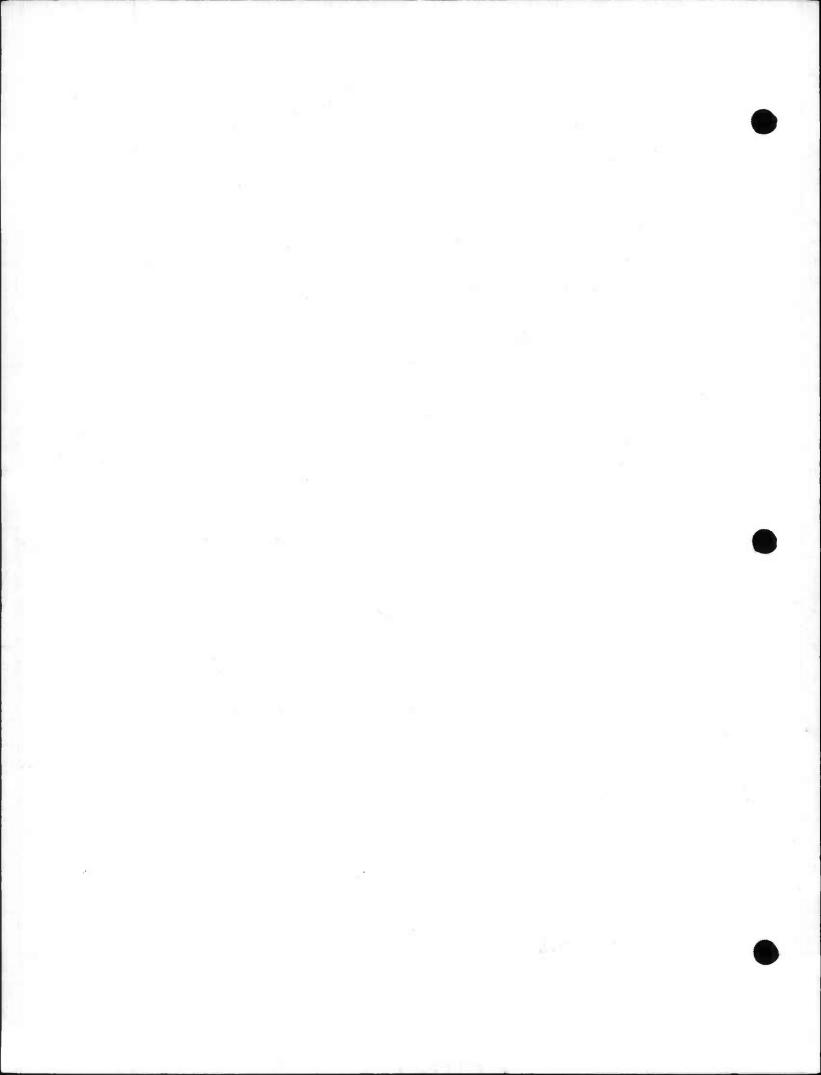
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the Hospital Completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It less 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	REGISTRAR		CERTIFI	CATE OF	DEATH	RE	G. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF D			3. TIME OF DEATH		
	Gordon Mu	Sm	ith		June	2.4	1995	1:15 a M			
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In)	rrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BI		a. BIRTI	HPLACE (State or Foreign		
	215 38 4323 1 BM 2		YRS.	MONTHS DAYS	HOURS MIN.	July 2		8 Wa	sh. D.C.		
H.	9a. FACILITY NAME (# not institution, give street and number 8603 Burnt Hickory		96. CITY, TOWN	OR LOCATION OF D	EATH		reder	TY OF DEATH derick			
ו 5	RESIDENCE OF DECEDENT										
DIRECTO	Md. 100. STATE Frederick		10d. INSIDE CITY LIMITS? 1 YES 2 NO								
ERAL	8603 Burnt Hickory		101. ZIP CODE 21701					10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
Y FUNER	1 Never Married 2 Married FORCES:	CEDENT EVER IN U.	2 NO	If yes, s	CENDENT OF HISPA pecify Cuban, Maxic S 2 M NO Specif	an, Puerto Rican,			E — American Indian, ik, White, etc.		
B	3 Widowed 4 Divorced	W.2			- 5				white		
	15, DECEDENT'S EDUCATION (Specify only highest grade completed)	10	Sa. DECEDENT'S L	SUAL OCCUPAT	ION	16b. KIND	OF BUSINE	SS/INOUSTRY			
4	Elementary/Secondary (0-12) College (1-4	or 5+)	life. Do NOT use	retired.)	lost or working						
<u> </u>	8		Physic	cian		Pri	vate	prac	tice		
COMPL	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle,					
BE C	Guy Murdoch Smith				Elizab	eth E	Sla	de			
OB	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	AOORESS (Street	and Number or Rural						
2	Lillian H. Smith		8603 1	Rurnt	Hickory	Cir	Fred	lorick	, Md 21701		
	20s. METHOD OF DISPOSITION	20b. Pl	ACE AND DATE OF					ION — City or To			
	1 ☐ Burial 2 Cremation 3 ☐ Ramoval from Sta 4 ☐ Donation 5 ☐ Other (Specify)		ry, crematory or oth	er place)		- 1					
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		SILLUI	1sburg	AND ADORESS OF FA	CILITY	SIIIT	hsbur	d. Md.		
j	+ 11m d 1/1:th	-		Hil	ton Fun	eral H					
-	23. PART I. Enter the diseasea, or complication	a sheet accorded at	no death De si		nesvill						
ı	shock, or heart fallura. List only on	e cause on sech	n ilne.	y enter the n	ode or dying, suc	m as cardiec (or realpirate	огу агтеат,	Approximate Interval Between Onset and Death		
	IMMEDIATE CAUSE (Final disease or condition ADENOCARCINOMA OF UNKNOWN PRIMARY PRIMARY										
I	DUE TO (OR AS A CONSEQUENCE OF):										
HILLAIION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										
Z	cause. Enter UNDERLYING										
	CAUSE (Disease or injury that initiated events	UE TO (OR AS A CO	ONSEQUENCE OF	:							
Ŧ	resulting in death) LAST										
2	BART II Other elemitiant conditions contained										
DICAL	PART II. Other aignificent conditione contribution	ng to deeth but	not resulting in	the underlyl	ng cause given in		WAS AN AUT		b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO		
						1 🗆	YES 2	-NO	COMPLETION OF CAUSE OF DEATH?		
E						_ /	Ť		1 TES 2 NO		
Z	DID_TOBACCO_USE_CONTRI	BUTE TO	CAUSE OF	DEATH	YES N	0 1			,		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				PLACE OF DEATH (C	neck only one)					
2	The state of the s	t 2 - ER/Outpette		OTHER: 4 - Nursing Ho	me 5 Besidence	6 Other (Spe	cify)				
=	(Mc	TE OF INJURY onth, Day, Year)	26b, TIME		JURY AT	26d. DEŞCRIB	E HOW INJU	RY OCCURED			
- 1	1 Accident Investigation	, 20,, 102,			YES 2 NO						
2	3 Suicide 28e. PL	ACE OF INJURY — liding, etc. (Specify)	At home, ferm, st	reet, factory, off	Ca			Number or Rural	Route Number,		
-	4 Homicide determined	talling, and (opochy)				City or Tow	ri, Siele/				
ן ב	29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the b	est of my knowled	ne death occurred	f at the time de	to and place, and du	to the sever(s)	and manner	no otolod			
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: On the beat								a) and manner as stated		
3		-	undo								
2	29b. SIGNATURE AND TITLE OF CERTIFIER	wange	1450	21	29c. LICENSE NU		29	d. DATE SIGNED	(Month, Day, Year)		
5	NAME AND ADDRESS OF STREET	- (0	0.0	00,	/-/		0/23	173		
	BYAN M. O GNOOP A		W. SEL	Print) ISNTH	ST. FI	2EDERI	CK.	4D Z	1701		
	-1	STRAR'S SIGNATU	IRE P. P. P.		/		/				
- 1	HIN 2 6 1995	Mark Son Little and Control	STROAM								



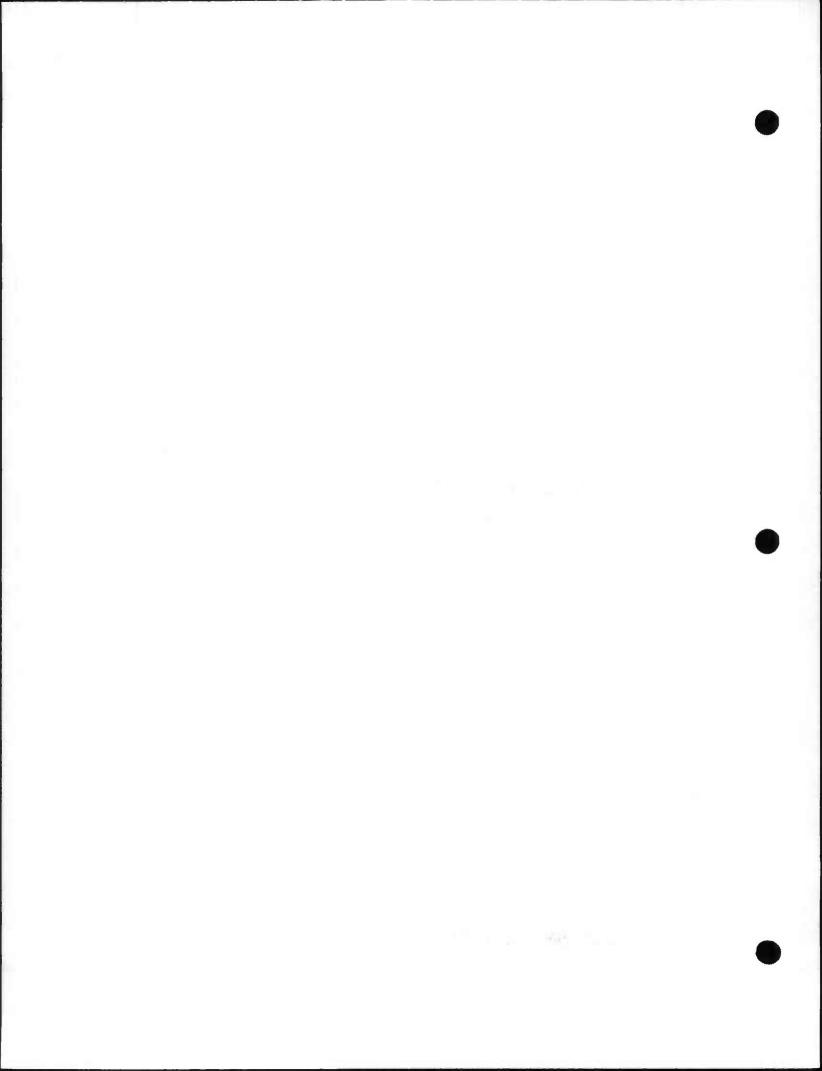
BALTIMORE, MARYLAND 21215-0020

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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First Middle Last 2. DATE OF DEATH 3. TIME OF DEATH ™1995 June 23, Lillian Elizabeth STONE 7:03 PM 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH B. BIRTHPLACE (State or Foreign 216-54-8421 98 Now 1896 HOURS Maryland permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Vindobona Nursing Home Braddock Heights Frederick RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Frederick Frederick 1X YES 2 □ NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21701 is after death. Page 6 may be retained by the hospital or attending physician.

The funeral director, page 5 should be detached for use as the burial-transit removal. 105 East Fourth Street U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 YOU IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puerto Rican, atc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married BY Specify White 3 X Widowed 4 Divorced COMPLETED 15. DECEOENT'S EDUCATION 16a. DECEOENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp. (Give kind of work done life. Do NOT use retired.) stary/Secondary (0-12) College (1-4 or 5+) Homemkaer Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surnam GEISER MC LAUGHLIN Ħ Curtis Minnie H notified 19a. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
105 East Fourth St., Frederick, Maryland 21701 Mrs. Doris E. Seeger å 20a METHOD OF DISPOSITION
1 Aburial 2 Cremation 3 Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of must Mount Clivet Cenetery, June 27, 1995 Frederick, Maryland 4 Donation 5 Other (Specify) examiner 22. NAME AND ADDRESS OF FACILITY
Keeney and Basford P.A. Funeral Home 21. SIGNATURE OF FUNERAL SERVICE LICENSEE with hours after death. MO0255 106 East Church St., Frederick, Md. 21701 medical filled in by t 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, shock, or heart fellure. List only one dause on each line. Interval Between ò **IMMEDIATE CAUSE (Final** Onset and Death cremation. event, the DOE TO (OR AS A CONSEQUENCE OF): disesse or condition resulting in death) completely burial. executed traumatic CERTIFICATION and (Sequentially list conditions, QUE TO (OR AS A CONSEQUENCE OF) prior to If any, leading to immediate cause. Enter UNDERLYING attending physician 8 certificate CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 death Mental PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. the 24a. WAS AN AUTOPSY PERFORMED? requires that the MEDICAL 24b. WERE AUTOPSY FINDINGS signed by the Alzheiners AMAILABLE PRIOR TO amy COMPLETION OF CAUSE 1 TYES 2 TONO Shows 1 TYES 2 NO peen DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 1 PHYSICIAN: UNCERTAIN MP Dept. 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one The certificate h item HOSPITAL: QTHER: 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 YES 2 NO PHYSICIAN: 1 Inpetient 2 ER/Outpetient 3 DOA the of 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCUREO marked, this c 1 Netural 2 Accident 5 Pending 1 YES 2 NO BY death OR ATTENDING After 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28 is i 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be DIRECTOR: / 4 Homicide determined TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT DE filed within 72 hours a IMPORTANT: If Item 2 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND /TUTLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) 出 0 D 35553 June 24, 1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) Judith Pasierb Henry MD 610 Ninth Avenue, Brunswick, Maryland 21716 31. DATE FILED (Month, Day, Year) 32. REMISTRARY SIGNATURE



DIRECTOR 99 28

Pages 1, 2, 3 should

permit.

BALTIMORE, MARYLAND 21215-0020

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executed

DIVISION OF VITAL RECORDS, P.O. BOX 68760

OR ATTENDING PHYSICIAN: The law

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TO THE HOSPITAL OF THE FUNERAL D DE filed within 72 ho HOSPITAL

FUNERAL hoours after death. Page 6 may be retained by the hospital or attending physician. In by the funeral director, page 5 should be detached for use as the burial-transit 1 Never Married 2 Married BY 3 🔀 Widowed 4 🗌 Divorced COMPLETED Elementary/Secondary (0-12) 17. FATHER'S HAME (First, Middle, Last) Elmer C. 76 BE notified 19a. IHFORMANT'S NAME (Type/Print) 2 Allan Steel 99 must 4 Donation 5 Other (Specify) examiner filled in by 6 IMMEDIATE CAUSE (Finsi and completely fille burial, cremation, disease or condition resulting in deeth) CERTIFICATION Sequentially list conditions, requires that the death certificate be exen signed by the attending physician a of Health and Mental Hyglene prior to If any, lasding to immediate cause. Enter UNDERLYING CAUSE (Disesse Dr Injury that initiated events resulting in death) LAST MEDICAL t. of PHYSICIAN: has be Dept. this certificate h 1 YES 2 NO

95 20710 Amender #7, 6/26/95, L.H., Fred. CO.

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT CERTIFICATION STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S HAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH June 19, 1995 Edna Carrie Stee1 11:20A MIN. Ma TCH 4, 1901 4. SOCIAL SECURITY HUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 91 MONTHS DAYS HOURS 820-01-0516 1 M 2 X F YRS. Maryland 9a. FACILITY HAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Northhampton Manor Nursing Home Frederick Frederick RESIDENCE OF DECEDENT 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. IHSIDE CITY Maryland Frederick Myersville 1X YES 2 | HO 10e. STREET AND HUMBER 10f. ZIP CODE 10s. CITIZEN OF WHAT COUNTRY? 10240 Rolling Ridge Court 21773 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 24 HO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 Specify: White 1 YES 2 NO Specify: 18a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIHD OF BUSINESS/INDUSTRY (Specify only highest grade comp (Give kind of work done life. Do NOT use retired.) College (1-4 or 5+) Homemaker Own home. 18. MOTHER'S HAME (First, Middle, Maiden Surname, Pope Alice M. Morrison 19b. MAILIHG ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 96. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21773 10240 Rolling Ridge Court, Myersville, Md 20b. PLACE AHD DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State Montgomery Crematorium 6/20 Bethesda, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. HAME AND ADDRESS OF FACILITY Olin L. Molesworth, P.A., Funeral Home deswatt 26401 Ridge Road, Damascus, Maryland 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate intarval Between Onset and Death DUE TO (OR AS A CONSEQUENCE OF): ~ 24 Hms 24 Hm

Protofle Myosard Attensilentie DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 NO 1 | YES 2 | HO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{N}\) UNCERTAIN \(\Boxed{1}\) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 Inpetient 2 ER/Outpetient 3 DOA 45 Huraing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF IHJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1) Natural м 1 YES 2 NO BY Investigation Accident 28a. PLACE OF INJURY — At home, larm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide determined 29a, CERTIFIER 1 SCENTIFY HD. INVSICIAH: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) MPDICAL EXAMPLER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

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29c. LICEHSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

30. NAME AHD ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

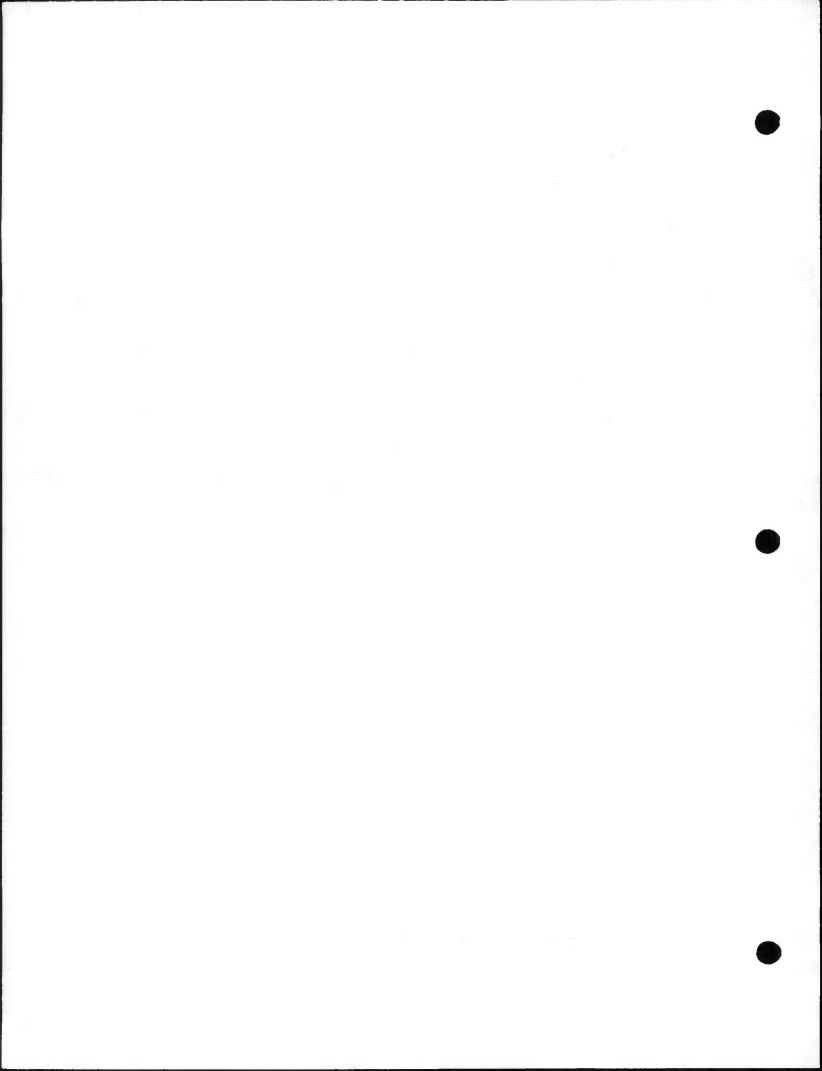
when to.

29b. SIGNATURE AND TITLE OF CERTIFIER

ANTHOR G. MANTED WP. 187 Though John A. Frelich, up. 21702

32. REGISTRANG SIGNATURE PARLER 31. DATE FILED (Month, Day, Year) JUN 2 1 1995

6-17-95



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 6 may be retained by the hospital or attending physician.

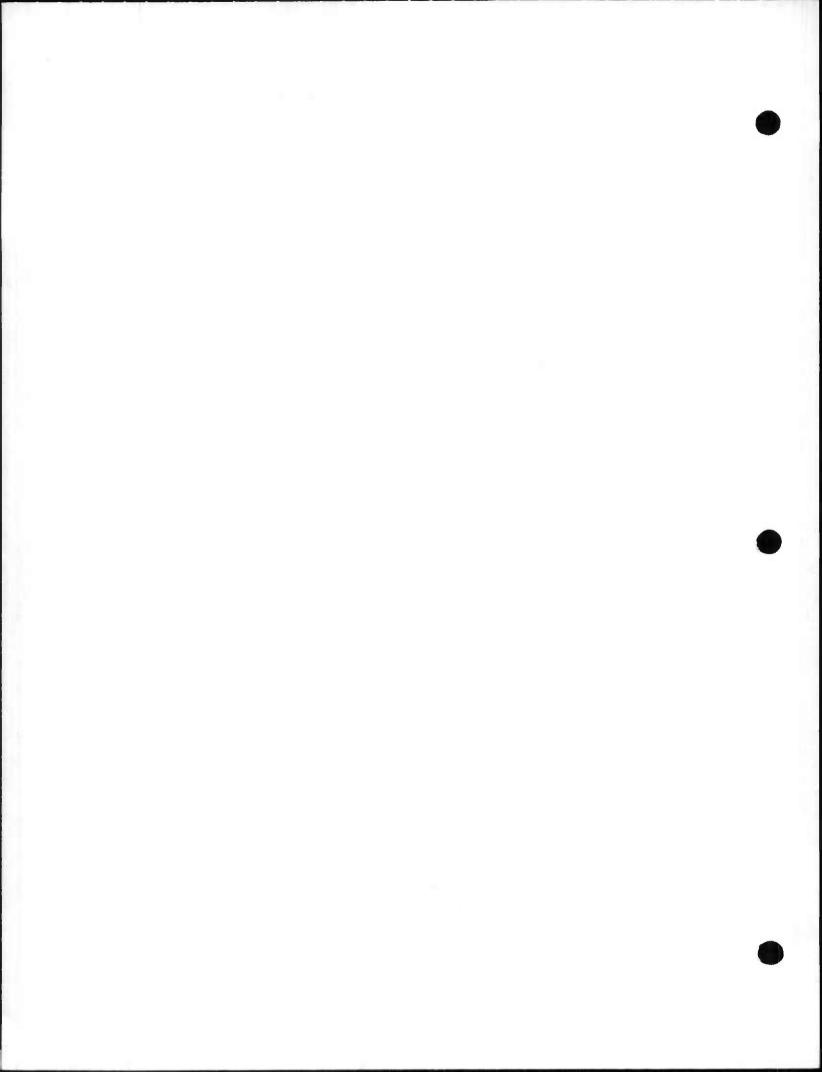
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filted in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filted within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO.

	REGISTRAR			TIFICAT				REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF				3. TIME OF DEATN
	RUTH BANNI	ISTER SLAI	DΕ				JUNE	19	1	995	10:24 A M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. lest bir	thday) IF INDE	R 1 YEAR	IF UNDER 24 HRS.	7. DATE OF		, 1		IPLACE (State or Foreign
	577-28-1522			YRS. MONTHS	-	HOURS MIN.	(Month, De	ly, Year)		Countr	γ)
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~	9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH									EATH	
Ö	201 Shady Glen Drive Capitol Heights Prince Georges										Georges
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	TV.									
<u>=</u>	DC	Washin	orton	ION				·	10d. INSIDE CITY LIMITS?		
											1 YES 2 NO
₹	10e. STREET AND NUMBER	ZIP CODE			10g. Cl	TIZEN OF W	WHAT COUNTRY?				
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FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARME	13.	. WAS DEC	ENDENT OF NISPA	NIC ORIGIN? (S	pecify Yes	or No-	14. RACE	- American Indian,
	1 Never Married 2 Married	FORCES? 1 YES	2 NO		If yes, spi	ecify Cuban, Maxico	an, Puarto Rica	n, atc.)		Bleck	c, White, etc.
BY	3€ Widowed 4 □ Divorced	ii rea, are tant on	DATES		1 🗆 163	2 NO Specif	ry:			Speck	
0.	15. DECEDENT'S EDU	JCATION	16a. DECEC	ENT'S USUAL (OCCUPATIO	DN .	16h KII	O OF BUS	INESS/IN		ack
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)		(Give I	and of work done NOT use retired.)	during mo	st of working	100.10			0031711	
2	Committee y/Secondary (0-12)	College (1-4 or 5 +)	0.7	l1							
×	17. FATHER'S NAME (First, Middle, Last)	1 year	I C.	Lerk						ernme	ent
	The state of the s					16. MOTHER'S NA					
띪	Isaac Clinton	Bannister					an Ell			Thoma	as
2	19a. INFORMANT'S NAME (Type/Print)		19b. M	AILING ADDRES	S (Street e	nd Number or Rural					3443
-	June Slade Coll	ins	201	L Shady	G1e	n Drive	Capit	01 H	eigh	ts Mo	1 20743-
	20e. METNOD OF DISPOSITION			DATE OF DISPO		me of	DATE	20c. LOC	CATION -	- City or To	wn, State
	1 Name 1 Name 1 Name 1 Name 1 Name 1 Name 2	Ioval from Stata	metery, cremete	ory or other place	ial i	Park	6-24	T.ai	ndov	er N	Md.
1	4 Donation 6 Other (Specify) Harmony Memorial Park 6-24 Landover Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Marshall's Funeral Home Inc.										
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	23. PART i. Enter the diseases, or	complications that cause	d tha death	. Do not ante	r tha mo	de of dying, suc					Approximata
	snock, or heart failure. List only one cause on each line.										intarval Between
	All and the state of the state									Onset and Daath	
	resulting in death) a. TERMINAL STAGE OF ENDOMETRIAL CANCER 5 month									5 months	
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Ē	of any, leading to immediata cause. Entar UNDERLYING										
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	CAUSE (Disease or Injury that initiated events	d		ilting in the U	ndariying	cause given in	Part I. 24	. WAS AN /		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
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BE 9 29b. SIGNATURE AND JITLE OF CERTIFIER

3t. DATE FILED (Month, Day, Year)

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-14 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the busial-transit nermit Page 1.2 should
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

95 20712 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH **1**995 June 18, CLAUDIE O. SMITH :48 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign Country) 1 🔀 M 2 🗆 F DAYS HOURS MIN. VRS 239-28-2031 March 21 1922 North Carolina Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR 5800 Woodland Drive Prince Georges Forest Heights RESIDENCE OF DECEDENT toa. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Prince Georges Forest Heights 1 X YES 2 NO FUNERAL 10s. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 5800 Woodland Drive 20745 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-11. MARITAL STATUS 14. RACE — American Indien, Black, White, etc. If yes, specify Cuben, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: 1 Never Married 2 Merried BY Specify: 3 Widowed 4 Divorced **Black** COMPLETED 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) 5th Gardener/Landscaper Nat'l. Capital Parks 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Melden Surneme) Hyman Smith Mary E. Mourning BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Gloria Smith 5800 Woodland Dr., Forest Heights, MD 20745 20e. METHOD OF DISPOSITION
1 □Puriel 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Mem. Cemetery 6/24 Suitland, 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Marshall's Funeral Home, Inc. mais 4308 Suitland Rd., Suitland, MD 20746 23. PART I. Enter the disesses, or complications that caused the deeth. Do not anter the mode of dying, auch as cardiac or reapiratory arrest, Approximats ahock, or heart failure. List only one cause on each line. Interval Betwe **IMMEDIATE CAUSE (Final** Onset and Death disesse or condition Metastatic cancer of the prostate months resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate . Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST

PART II. Other algorificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE T TES 2 NO OF DEATN? 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\mathbb{Z}\) UNCERTAIN \(\Boxed{1}\) 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) EXAMINER? X X 1 YES 2 NO HOSPITAL: 4 ☐ Nursing Nome 5A Residence 8 ☐ Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED 1 Netural M 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 3 Sulcide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 29e. CERTIFIER

CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. 2 MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner ee stated.

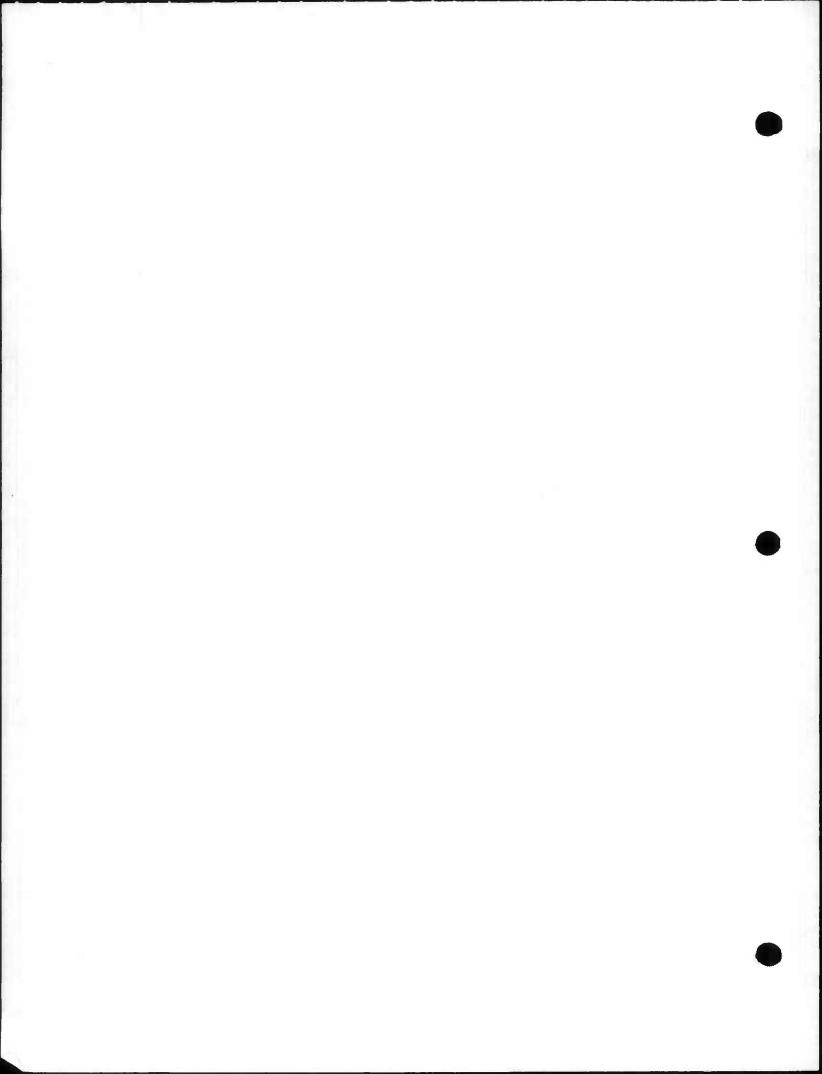
Philip Wisotsky M.D. 6188 Oxon Hill Rd. Oxon Hill, Md 20745

29c. LICENSE NUMBER D = 18545

32. REGISTRAR'S SIGNATURE d'avelegi-ha

30. NAME AND AMORESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

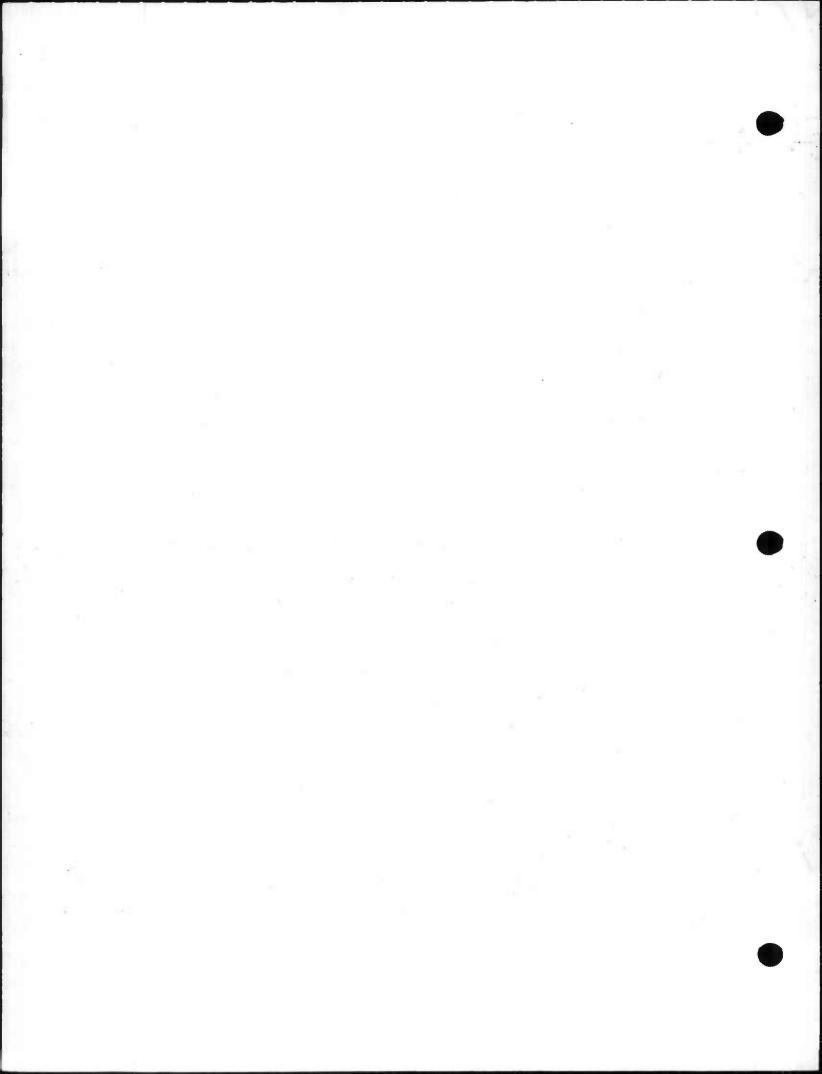
29d. DATE SIGNED (Month, Day, Year)



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DIVISION OF VITAL RECORDS, P.O. BOX 68760	TALL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed wi
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH JUNE 13 995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 6. BIRTHPLACE (Sta 1 M 2 F HOURS 9harke Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH MARYLAND HOSPING DIRECTOR MINCE DECEDENT 10b. COUNTY IOC. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? permit. 1 XES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? use as the burial-transit 0641 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-It yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. It yes, specify Cubs 2 Married IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced Specify: COMPLETED 15. DECEDENT'S EDUCATION ecify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY è College (1-4 or 5 +) detached 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle notified at BE page 5 should 2 P . METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION /No must urial 2 Cremation 3 Removal from State funeral director, nation 5 Other (Specify) medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY L Lal Ken completely filled in by the infall, cremation, or removal. 9-23. PART I. Enter the diseases, or complications that couled the death. To not enter the mode of dying, such as cardiec or respiratory arrest, Approximata shock, Or heart feiture. List only Dne cause Dh each line. intervai Between **IMMEDIATE CAUSE (Final** Onset and Death the disease or condition SEVERE ATHEROSCLEROTIC CORONRY HEART DISEASE. YEARS. event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF): prior to burlal, traumatic CARDIOPULMONARY ARREST MINUTES and Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate the attending physician CERTIFICATI e. Enter UNDERLYING ANTEROSEPTAL MYOCARDIAL INFARCTION. WEEKS. CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST UROSEPSIS 6 DAYS. been signed by the atte t. of Health and Mental PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO CHRONIC ALCOHOLISMS, WITH CACHEXIA, DEMENTIA, any COMPLETION OF CAUSE YES 2 NO OF DEATH? Shows PANCREATITIS, HEPATITIS, PRESACRAL DECUBITUS UICER. 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES \(\Boxed \) NO \(\Boxed \) UNCERTAIN \(\Boxed \) Dept. 23 has 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Item Item State HOSPITAL: 1 Nonpetient 2 ER/Outpetient 3 DOA this certificate OTHER: 1 TES 2 DIO ng Home 5 - Residence 8 - Other (Specify) the marked, or 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED with 1 1 Natural 1 YES 2 NO BY After death 2 Accident 28a. PLACE OF INJURY — At home, term, street, factory, offica building, atc. (Specify) 3 Suicida 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) .00 8 Could not be COMPLETED THE FUNERAL DIRECTOR: 4 Homicide 28 determined Item 29a. CERTIFIER 1 👿 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(a) and menner as stated. TO THE FUNERAL D
be filed within 72 ho
IMPORTANT: If 16 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE D12884 June 16 1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PETER W.YIM M.D. 7900 OLD BRANCH AVE.SUITE 101, CLINTON, MARYLAND 20735 31. DATE FILED (Month, Day, Year)

32. REGISTRAR'S SIGNATURE d'avelor Kardell



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. **BALTIMORE, MARYLAND 21215-0020** DIVISION OF VITAL RECORDS, P.O. BOX 68760

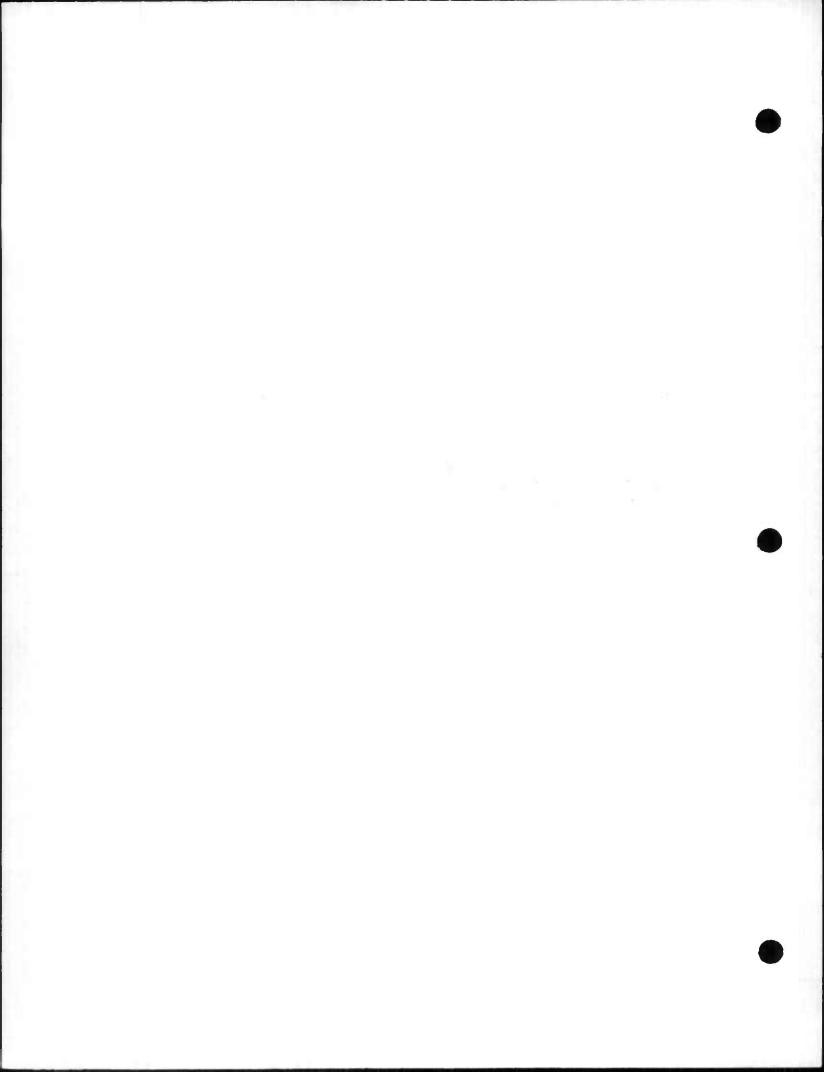
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 - REGISTRAR		CERTIFICA	TE OF	DEATH	REG. N	0.				
1. DECEDENT'S NAME (First, Middle, Last) ANTHONY S					2. DATE OF DEATH MONTH May 23,	1 995	YEAR	3. TIME OF DEATH 6:55P. M		
4. SOCIAL SECURITY NUMBER 577-96-0632	1 XM 2 □ F 32	M 2 F 32 YRS. MONTHS DAYS HOURS MIN. 1 (Mgrith, Day, Nair)						PLACE (State or Foreign		
	9a. FACILITY NAME (# not institution, give street and number) Wellington Nursing Home 9b. CITY, TOWN OR LOCATION OF DEATH Clinton 9c. COUNTY OF Prince									
WEITINGTON N RESIDENCE OF DECEMENT 10a. STATE D.C. 10b. COUNT	Υ	10c. CITY, TOWN OR LOCATION Washington								
10e. STREET AND NUMBER 2800 N. Stre 11. MARITAL STATUS **Nover Married 2 Married	IZEN OF W	1 YES 2 NO								
3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. FORCES? 14 YES 2 [IF YES, GIVE WAR OR DATES	IIC ORIGIN? (Specify Y n, Puerto Rican, atc.)	es or No—	14. RACE	— American Indian, White, etc.					
15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) 17. FATHER'S NAME (First, Middle, Last)	e completed)	DECEDENT'S USUA (Give kind of work di life. Do NOT use retin Unemp	one during mo: ed.)	st of working	16b. KIND OF B	USINESS/INC	DUSTRY			
17. FATHER'S NAME (First, Middle, Last) James San	in morners									
198. INFORMANT'S NAME (Type/PTIN)										
1 Burial 2 X Cremetion 3 Ran 4 Donetion 5 Other (Specify)	noval from Stata comptery, R1V6	cremetory or other plie erdale	Crema 22. AMEAN	atory 5	/25/95 F Ster Fur	eral	dale Hor	e, Maryland		
shock or flear fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24e. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO										
25. WAS CASE REFERRED TO MEDICAL	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERBLED TO MEDICAL 26. PLACE OF DEATH (Check galf one)									
EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Oulpatient	3 DOA 4	HER: Nursing Home	5 Residence	6 Other (Specify)					
27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJU WOI 1 Y		28d. DESCRIBE HOW INJURY OCCURED					
3 Suicide 8 Could not be 4 Homicide detarmined	28a. PLACE OF INJURY — At building, atc. (Specify)	home, larm, atreet,	factory, office		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
	ICIAN: To the best of my knowledge, ER: On the beals of examination and/c				time, data and place, a	nd due to th	e cause(s)	and manner as stated. (Month, Day, Year)		
30. NAME AND ADDRESS OF PERSON WH					03 ==:		0	-		
Laxmi N. Bert	Va, MD., //UU		anch	Ave, #Cl	UI,Clin	ton,	Mary	land.2073		

July a aversor hardell JUN 21 1995



TO THE HOSPITAL OR ATENDING PHYSICIAN: The law requires that the death certificate be executed withings hours after death. Page 6 may be retained by the hospital or attending physician.

ACTHE FUNEDAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygher prior to burial, cemariting, or removal.

IMPORTANT: Afterm 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be matitied at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1	-	STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO

	HEGISTHAR		CERTIF	ICALE	OF DEAL	П	F	IEG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF		.0		3. TIME OF DEATH
	IRMA P. SMITH						June 1	1 /4 DA		YEAR	2.05 A H
1	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. last birthday)	IF UNDER 1	TEAR IF UNDER	24 MBC	7. DATE OF I		. 333	A DIPTUR	2:05 A. M
	127 1/ 7202	1 □ M 2 😾 F			AYS HOURS	MIN.	(Month, De	ly, Ybar)		Country)	
	137-14-7392	41	80 YAS.				July 4	+, 19		Virgi	
~	9a. FACILITY NAME (If not institution, give			9b. CITY, T	OWN OR LOCATIO	ON OF DE	HTA		9c. COUN	ITY OF DE	ATH
DIRECTOR	Manor Care Nursi	ng Home		Ве	thesda				Mont	gomer	cy County
5	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Washington, D.C.										
1 2										10d. INSIDE CITY LIMITS?	
										1 X YES 2 NO	
١₹	10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZ	EN OF WI	IAT COUNTRY?
FUNERAL	1712 Verbena Str	eet, N.W.			200	12			Uni	ted 9	States
5	11. MARITAL STATUS	12. WAS DECEDENT EV	ER IN U.S. ARMED	13. WA	S DECENDENT OF	F HISPAN	IIC ORIGIN? (S	pecify Yea			- American Indian, White, atc.
	1 Never Married 2 Married	FORCES? 1 X	YES 2 NO		es, specify Cuban YES 2 X NO			n, etc.)		Black, Specify:	
B	3 Widowed 4 Divorced				24					opcony.	Black
	15. DECEDENT'S EDU (Specify only highest grad		16a. DECEDENT'S				16b. KIN	D OF BUS	INESS/IND	USTRY	
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	se retired.)	ing most of working	9					1
.] 💆		4	Police	Office	er		Cit	v Po	1ice	Dena	rtment
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				16. MOTH	ER'S NA	ME (First, Midd)				
	George Proctor				Mar	110	Melton				
BE	19a. INFORMANT'S NAME (Type/Print)		19h MAII IN	AODRESS (S	Street and Number	_			State 7/a	Codel	
2	Ron Smith										60100
8	20a. METHOD OF DISPOSITION				nd Ave.	, # A					
	1 S Buriel 2 Cremation 3 - Ren	ovel from State	20b. PLACE AND DATE cemetery, cramatory or it	Aba-ata-1			1			City or Town	
	4 Donation 6 Other (Specify)		Lincoln M	emoria				Sui	tland	l, Ma	ryland
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE			ME AND ADDRES			II	. т.		
5	77/10 X.	MMANA			t Lincol						MD 20722
	23. PART I. Enter the diseases, or	complications that ca	used the death. Do	oot enter th	a mode of dule	15 Du	Ig Ku.	, DI	entwo	10u,	
	ahock, or heart fellure.	List only one cause	on each line.	rot urrar tr	o mode or dyn	ig, auci	1 ca cardisc	or respir	etory stri	rat,	Approximate intervsi Between
	IMMEDIATE CAUSE (Fine)	Inanitio	n								Onset and Death
	reaulting in death)	8									5 Weeks
	*		AS A CONSEQUENCE C								
N	Sequentially list conditions,		ic Lymphag								
CERTIFICATION	if sny, lesding to immediate csuse. Enter UNDERLYING	,	AS A CONSEQUENCE O	*	-	1 -					92.53
2	CAUSE (Disease or injury		a involvir		Lung ar	nd L	iver				5 Months
F	that initiated events resulting in death) LAST	DOE TO (OR	AS A CONSEQUENCE O	F):							
: E	resulting in deading exist	d									
	PART II. Other significant condition	ns contributing to dea	th but not resulting	In the unde	rlying cause of	lven In	Port I 24	. WAS AN	urmopey	24h Y	WERE AUTOPSY FINOINGS
EDICAL					mymg cadec g	V (211 111	7 (1) (1)	PERFORI		A	WAILABLE PRIOR TO
ā							10	YES 2	К но		COMPLETION OF CAUSE OF CEATH?
Σ										1	YES 2 NO
z	DID TOBACCO USE CONT	RIBUTE TO CAUS				ERTAIN	1 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA		(one)						
S	1 - YES 2 X NO	1 Inpetient 2 ER	/Outpatient 3 DOA	OTHER:	Home 5 - Res	idence	8 Other (Sp	ecity)			
E	27. MANNER OF DEATH	28e. DATE OF INJU		E OF 26	c. INJURY AT WORK?		28d. OEŞCRII	BE HOW IN	JURY OCC	URED	
ВУ	1 X Netural 5 Pending 2 Accident Investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			YES 2	NO					
	3 Suicide 8 Could not be	28e. PLACE OF IN.	JURY — At home, farm,	street, factory	, office		28f. LOCATIO	N (Street ar	nd Number	or Rural Ros	ute Number,
ED	4 Homicide determined	building, etc.	(Specify)				City or To	wn, State)			
1	29a. CERTIFIER	IOLANI. To the best of				_					
₩ B		ICIAN: To the best of my I									
COMPLET		ER: On the basis of axemi	nation and/or investigation	on, in my opin	ion, death occure	d at the	time, deta and	placa, and	due to the	cause(a) a	and manner as stated.
ш	THE SIGNATURE AND PITLE OF CENTERS	7- 17	11 \		296. LICES	NSE NUM	шен		29d. DATE	SIGNED (A	Month, Day, Year)
0 8	Willem 19	Scowale	e MO		192	25			Ju	ne 1	5, 1995
2	30. HAME AND ADDRESS OF PERSON WI	O COMPLETED CAUSE O	F DEATH (ITEM 27) (Type	Print)							
	William J. Brown	lee, M.D	2642 12th	Stree	et. N.E.	. W:	ashino	ton.	D.C.		į
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S	SIGNATURE			7 111		20119	2.0.		
1	II JUN 21 1995 94	ha d'avelor K	andall								

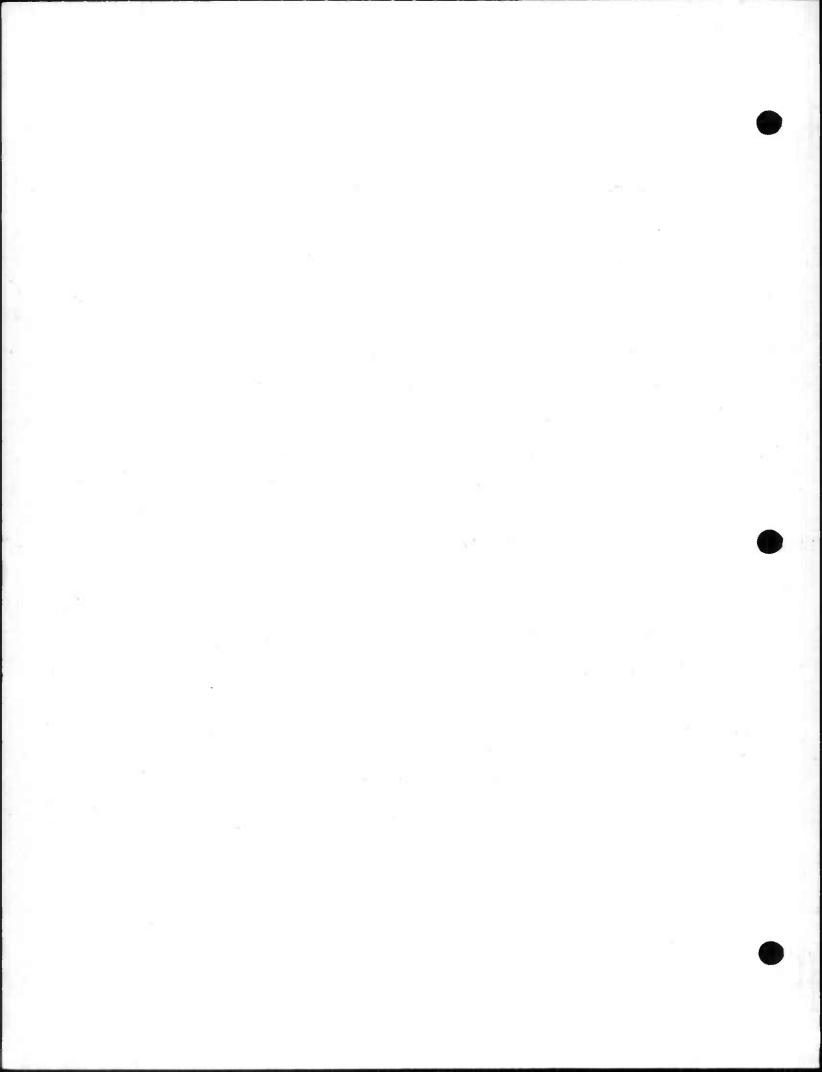
BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPING OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be find within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

-	FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL	HYGIENE REG. NO.

	1 - STATE REGISTRAR	SIAIE UF I	MAKYLAND /				DEAT		/ENT/	AL HYGIEN REG. NO	E		
	1. DECEOENT'S NAME (First, Middle, Last)						DEAL			E OF DEATH		VEAR	3. TIME OF DEATH
	ELLEN				SM:	ITH			J'O'	NE .	ľ8 1	995	1:29 A _M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lest		IF UNDER	1 YEAR	IF UNDER	24 HRS.	(Month Day Viser) Country)				PLACE (State or Foreign
	212–30–0805	1 M 2 X F	76	YRS.						rch 14,	1919	Mary	/land
œ	9e. FACILITY NAME (If not institution, give				9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH								
5	SUBURBAN HOS	PITAL			BI	STHE	SDA				MON	TGOM	IERY
DIRECTOR	10a. STATE 10b. COUN	TY		10c. CIT	Y, TOWN (R LOCAT	ION				10d. INSIDE CITY		
	Maryland Mont	gomery		Wh	eato	n							Y LIMITS?
3AL	10e. STREET AND NUMBER			10f. ZIP CODE									HAT COUNTRY?
NA I	2272 Georgia W	7					2090					U.S.	A.
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	T EVER IN U.S. ARI YES 2 X N WAR OR DATES	MED IO	ED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify 1) If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ▼ NO Specify:					IN? (Specify Yes Rican, atc.)	a or No— 14. RACE — American Indian, Black, White, atc. Specify:Black		
8	15. DECEDENT'S ED	UCATION	16e, DEG	CEDENT'S	USUAL O	CCUPATIO	N		16	b. KIND OF BUS	INESS/IN	DUSTRY	
H	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4 or 5	- Ma	ve kind of Do NOT u	work done se retired.)	during mo:	at of working	g					
MPI	Secondary		Ι	omes	tic	_				Self			
COMPLETED	17. FATHER'S NAME (First, Middle, Last) John Smith									Middle, Meiden S Smith			
BE	19e. INFORMANT'S NAME (Type/Print)		196	. MAILING	ADDRESS	(Street e				nber, City or Tow		n Codel	
7	William Smith		2	2272	Geor	gia	Wood	s Pla	ace	, Wheat	on,M	aryla	and 20902
	20e, METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Res	noval from State	20b. PLACE A cemetery, crer	matory or o	ther placel	Lim	coln		6%	1E 20c. LQ 22 S111	tlan	City or Tow	eryland
	4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L	ICENSEF	Memori	al F	'ark	Ceme	terv						
	· Charles		Best	1 1									Mortuary 0 20748
	23. PART I. Enter the diseases, or	complications the	t caused the de	ath. Do r	not enter	the mo	de of dyle	ng, auch	88 CB	rdiac or respi	ratory an	reat,	Approximeta
	ahock, Or heart failure. List only one cause on each line. Interval Between Onset and Death												
	disease or condition resulting in death) a. Multiple lymes												
	OUE TO (OR AS A CONSEQUENCE OF):												
NO	Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF):												
ÄŢ	if any, leading to immediate cause. Enter UNDERLYING	00E 10	(OH AS A CONSEC	MENCE O	r):								i 1
표	CAUSE (Disease or Injury that initiated events	C. DUE TO	(OR AS A CONSEO	UENCE O	F):								
CERTIFICATION	resulting in death) LAST	d											
	PART II. Other algnificant condition	na contributino to	death but not re	euiting	in the un	deriving	COURS O	luen in D	David I	24a, WAS AN	ALITORNA	Lan	
EDICAL				Journing		derrynng	couse g	IVON III.E	art 1.	PERFOR	MED?		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
									_	1 YES 2	□ NO		OF DEATH?
. M	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEAT	TH YE	SΠI	ио П	UNC	ERTAIN					1 YES 2 NO
IA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				TH (Check		-						
SIC	1 X YES 2 NO	HOSPITAL:	XER/Outpetient 3	□ DOA	OTHER		6 🗆 Res	sidence 6	□ Oth	er (Specify)			
PHYSICIAN	27. MANNER OF DEATH	28e. DATE OF (Monifh, D		26b. TIM INJ	E OF URY	28c. INJU	JRY AT		28d. DE	SCRIBE HOW II	JURY OC	CURED	1 .
B	1 Natural 5 Pending Investigation	6/17	7/95	214	1 00 /5	1 🗌 Y		1	Su	Get	stral	Chty	, vehicle
8	3 Suictde 6 Could not be 4 Homicide determined	28e. PLACE O building,	F INJURY — At horate. (Specify)			ory, office		1		CATION (Street a or Town, State)	nd Number	or Rural Ro	oute Number,
5	29e. CERTIFIER			Day	7		_		7	rya Are	ul a	rd R	mdolph Road
COMPLETED	(Check only one) 2 MEDICAL EXAMIN	ER: On the best of each											enty May (and
EC	295. SIGNATURE AND TITLE OF CERTIFIE							NSE NUMB	_				(Month, Day, Year)
100	Theretire	4. Kr	9 w	2)				м. Е			.		19.1995
2	30. NAME AND AODRESS OF PERSON W	HO COMPLETED CAUS	SE OF DEATH (ITEM	27) (Type,	Print)		U.C.	e l'i e l'i	•		U	ONE	19,1990
		·King	111	Pen	n St	ree	t. I	Balt	imo	ore, M	larv	land	21201
	31. DATE FILED (Month, Day, Year)	32. REGISTRA	R'S SIGNATURE										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an opposed by the state of the second physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

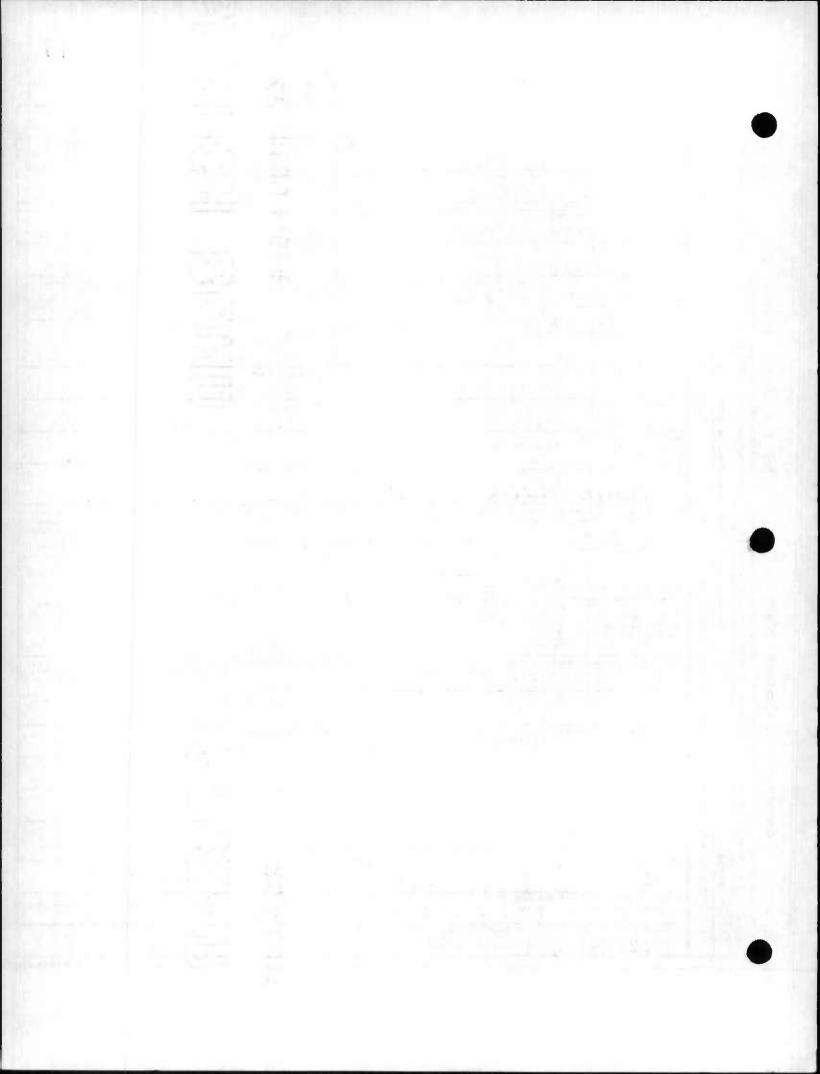
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

- 6										110.110			
-1	- 8	MONTH DAY YEAR											3. TIME OF DEATH
		SANDRA	SAUNDE	ERS					APRI	L 22	, 19	95	6:55 P _M
			V	AGE (In yrs. las		IF UNDER 1 YE		UNDER 24 HRS.	7. DATE OF	BIRTH Day, Year)		8. BIRTHP Country)	LACE (State or Foreign
	1	579-92-9488	□ M 2 1 F	3	6 YRS.	ONTHS DA	YB HO	URS MIN.	JAN.	4, 1	959		HINGTON, DO
		Se. FACILITY NAME (If not institution, give street	and number)		8	b. CITY, TO	WN OR LO	CATION OF E				NTY OF DE	
	8	HYATTSVILLE HEAL	THCARE	CENT	ER	HY	ATT	SVILI	E		PRI	NCE	GEORGES
	ECTOR	RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY											
	C		0500050	•		TOWN OR L						1	10d. INSIDE CITY
	ō		GEORGES	5	H	ATTS							YES 2 NO
	M.	106. STREET AND NUMBER				150	10f. ZIP						IAT COUNTRY?
	FUNERAL	6500 RIGGS ROA								TED	STATES		
	5	11. MARITAL STATUS 12 12. Wever Married 2 Merried	YES 2 AR	NO If yes, specify Cuban, Mexican, Puerto Rican, etc.)					14. RACE - Black,	- American Indian, White, etc.			
	BY	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES		1 🗇	YES 2 X	NO Speci	Hy:			Specify	ACK
		15. DECEDENT'S EDUCATI	ON	16a, DE	CEDENT'S US	BUAL OCCU	PATION		16h a	(IND OF BUS	LINESS/INF		. NOK
	H	(Specify only highest grade com		(Gi	tve kind of wor Do NOT use i	rk done durin		working	100.		3114233/1142	Josini	
	7	12	onege (1-e or 5 +)	N	URSES	SAIL	F		N	URSI	NG		
nce.	COMPLETED	17. FATHER'S NAME (First, Middle, Last)				, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		MOTHER'S N					
100 100		JOSEPH SAUNE					MARY	/ SCO	TT				
fled	BE	19e. INFORMANT'S NAME (Type/Print)		198	. MAILING A	DDRESS (St	eet end N	umber or Rural			n, State, Zip	Code)	
be notified at once.	2	HENRIETTA SIMMON	15	20	628 M	1YRTL	E A	VE.,	VE W	ASH.	. DC	20	0018
2		20e METHOD OF DISPOSITION 1/ Burlet 2 Cremetton 3 Removal		20b. PLACE		DISPOSITIO	N (Name o		OATE	_		City or Tow	
Ē		4 Donation 5 Other (Specify)	from State	HARM	DNY OTO	EMO F	IAL	PK		L	ANDO	VER.	MD.
iner		21. SIGNATURE OF FUNERAL SERVICE LICENS	BEE	0				DORESS OF F	ACILITY C	APIT			
жаш		* HALLA SIK	MM	XALL	DIV	1/12	E M	ADVI /					
100		23. PART I. Enter the diseases or complications that caused the deetit, Do not enter the mode of dying, such as cardiac or respiratory arrest,											Approximate
Ted.		shock, or heart fellure. List	only one cause of	on each line			251 1410						Interval Between
2		iMMEDIATE CAUSE (Final disease or condition	ACOUT	ACQUIRED IMMUNE DEFICIENCY SYNDROME								UNKNOWN	
E.		resulting in death) DUE TO (OR AS A CONSEQUENCE OF):											
3	_	INDAMENTAL D										UNKNOWN	
Tal	0	Sequentially list conditions, DIJE TO (DR AS A CONSEQUENCE OF)										OMATOWN	
ITA	¥	If any, leading to immediate cause. Enter UNDERLYING HEPATITIS C									UNKNOWN		
اق	E	CAUSE (Disease or Injury that initiated events	DUE TO (OR	OR AS A CONSEQUENCE OF):									OZIZZA O MZ
0 70	CERTIFICATION	resulting in death) LAST											
any injury, or other traumatic event, the medical examiner must	_												
三	MEDICAL	ANEMIA, LEUKOPENI					lying ca	use given ir	Part I.	PERFOR			WERE AUTOPSY FINDINGS
\$ an	ă	MYCOBACTERIUM AVI							_	T YES 2	M NO		COMPLETION OF CAUSE DF DEATH?
shows	X	THEODROIDE AVI	- CIT TIVITAL	GEDDOL	A LIKE							1	YES 2 NO
23	AN	OF MRC CACE DEFENDED TO MEDICAL											
or item 23	PHYSICIAN		OSPITAL:			OTHER:		OF DEATH (C					
	17S	1 YES 2 NO 1	Inpatient 2 ER		28b, TIME			Residence					
marked,		1 Natural 5 Pending	(Month, Day, Y		INJUF	RY	WORK?		26d. DEŞC	RIBE HOW I	NJURY OC	CUHED	
Ē	B	2 Accident Investigation	28e. PLACE OF IN.	IIIRV — At bo	me form etc			2 NO	204 1 004	ION (Street	and Months	as Burnt Bo	uda Atuahan
28 is	E	3 Suicide 8 Could not be 4 Homicide determined	building, etc.		, , , , , , , , , , , , , , , , , , , ,	est, factory,	Office			Town, Stete)		or nursi no	ule Number,
E	LETEI	29a, CERTIFIER . X CERTIFICAL PARAGOLA											
IMPORTANT: If Item	COMPL	Contact any 1 CERTIFTING PHYSICIAL											
ANT	00	2 MEOICAL EXAMINER: C	on the parts of examin	namon eng/or i	investigation,	in my opini				nd place, er			
S	BE	296. LICENSE NUMBER 29d. DATE SIGNED (Month										Month, Day, Year) 27 1995	
X	0	30. NAME AND ADDRESS OF PERSON WNO CO	OMPLETED COURSE	O A A A	107.7	h-(nd)		5014	,,			Lati	-,, -,,,,
		LEWIS HILLIARD DENN					ENRE	ELT RD	#U-1	COLLI	EGE P	ARK.	MD 20740
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S		320							,	
			Davidson A	ardall									
	- 13	TULI NO LULI											



Pages 1, 2, 3 should

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

PITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within or hours after death. Page 6 may be retained by the hospital or attending physician.	ERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans		
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NDIN	: After	r dea	To all
TE	CTOR	in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	To see the second on these 23 above and latines of the second the second and second and the second is
OR A	DIRE	DOURS	- Same
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0	H	=	6

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH (NMN) Rosetta Shorter June 25 1995 7:07 A: 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. DAYS HOURS 1 - M 2 XX YRS. 214-30-0712 November 934 Virginia 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Physicians Memorial Hospital LaPlata Charles RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Charles Waldorf 1 YES XX NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 11870 Oak Manor Ct. 20601 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuban, Mexicen, Puerto Rican, atc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. ☐ Never Married 2 ☐ Married 1 TES ZONO BY Specify: 3 Wildowed 4 Divorced Specify: Black. COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 8 Cook Restaurant 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Oscar Belfield BE Annie Hope 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Christopher Belfield Same as #10 9 20e. METHOD OF DISPOSITION
1 Å Buriat 2 ☐ Cremetion 3 ☐ Ramovat from State 20b. PLACE AND DATE OF DISPOSITION Frame of 29, 1995 20c. LOCATION — City or Town, State Zoin Baptist 4 Donation 5 Other (Specify) Welcome, Maryland Church 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Williams Funeral Home, P.A. Rt. 225 & Glymont Rd., Indian Head, N M00668 d 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or hasry failure. List only one cause on each line. Intarval Betwe IMMEDIATE CAUSE (Final Onset and Death Ē disesse or condition SEPTICEMIA FEW DAYS resulting in dasth) DUE TO (OR AS A CONSEQUENCE OF): CONGESTIVE HEART FALIURE EEW DAYS CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, lasding to immediata cause. Entar UNDERLYING CHOLECYSTECTOMY FEW DAYS CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PULMONARY HYPERTENSION HAND YEAR! PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AWALABLE PRIOR TO COMPLETION DF CAUSE PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? DIARETER 1 TYES 2 NO DF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA ng Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural М 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER

(Chark note)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(e) end menner ea stated. 2 __ MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and manner ea stated. TO THE FUNEI
TO THE FUNEI
De filed within 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 6/25/9 D-21173 2

11345 Pembrooke Square Suite #104 Waldorf, Md. 20603

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

Davidear Randall

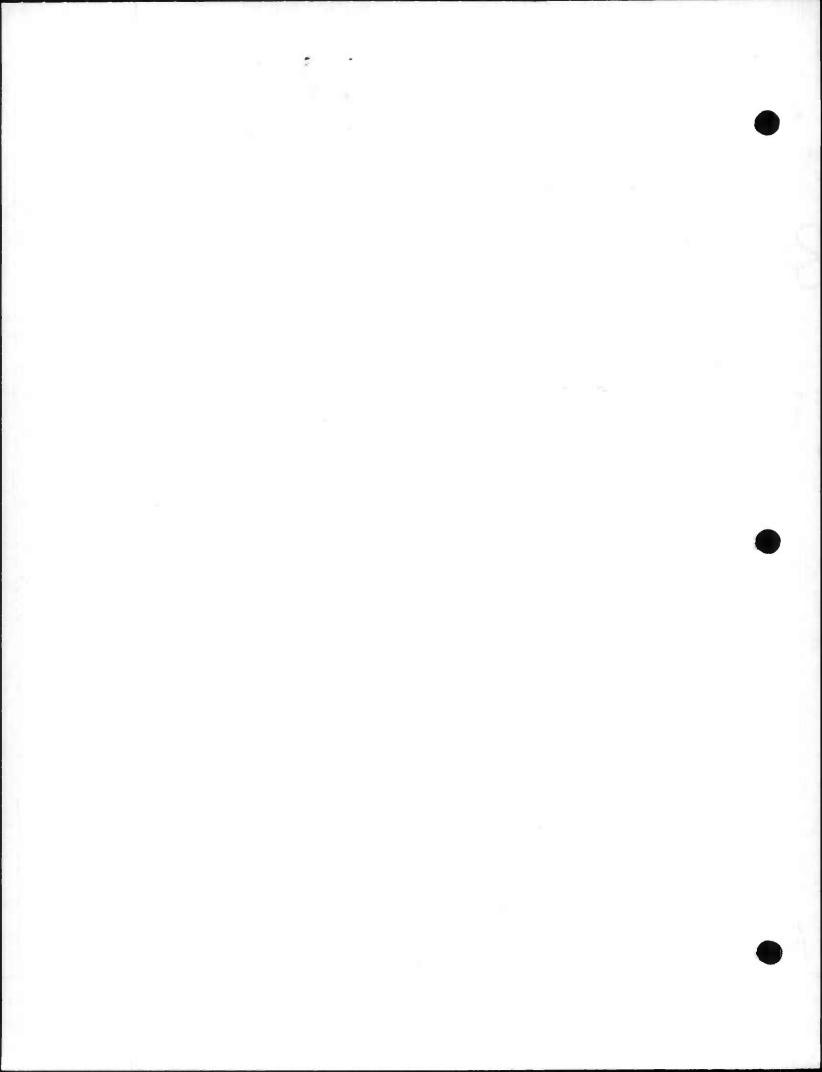
Niran P. Sharma MD

IIIN 2 8

1995

31. DATE FILED (Month, Day, Year)

DHMH-16 Rev 1/89



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 35 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO BE COMPLETED BY FUNERAL DIRECTOR

BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

2

4 Homicide

31. DATE FILED (Month, Day, Year)

JUN 2 8 1995

					3-00			J	J	20119
1 - STATE REGISTRAR	STATE OF N	/ARYLAND /	DEPAR	TMENT OF H	EALTH AND	MENTAL				
1. DECEDENT'S NAME (First, Middle, Le. MARY JOY	1			IOATE OF	DEATH	WONTH	OF DEATH	AY	YEAR	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER	5. SEX		st birthday)	IF UNDER 1 YEAR	IF INDER 24 HRS		-	4		1.0
276 01 0512	1 □ M 2XXF		YRS.	MONTHS DAYS	HOURS MIN.	(Month	Day, Year)		Count	ry)
9a. FACILITY NAME (If not institution, give	e street and number)	84		9b. CITY, TOWN (OR LOCATION OF D		26, 1			
Fallston Gene	ral Hospit	al						1		
RESIDENCE OF DECEDENT									110	HIOLU
			10c. CIT	,			110			10d. INSIDE CITY LIMITS?
10e. STREET AND NUMBER								T 40+ CIT	TZEN OF Y	
807 Wiesser Cou	rt.			"				lug. Cit		
11. MARITAL STATUS		T EVER IN U.S. AR	MED	12 WAS DEC			1010-M			
1 Never Married 2 Married	FORCES? 1	YES 2 X		if yes, sp	ecity Cuban, Maxic	en, Puerto R	(Specity ve	s or No-	14. RACI Blaci	k, White, etc.
3 Widowed 4 Divorced	11 123, 0172	HI OR DATES		I TES	Z XNO Speci	ny:			Speci	"White
						16b.	KIND OF BU	SINESS/INI		
Elementary/Secondary (0-12)		life	. Do NOT us	e retired.)	ist or working	U.	S. C	over	nmen	t
			Cle	erk		Sc	cial	Secu	rity	Adm.
	T						iddle, Maiden	Sumame)		
	Joyner									
	orn									185
20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Ref 4 Donation 5 Other (Specify)	amoval from State	20b. PLACE	AND DATE (OF DISPOSITION (Na	ame of	DATE	20c. LC	CATION -	City or To	own, State
* Styles (7. Alug	ls		Howard	K. MCC	omas	III F	unera	al Ho	ome, P.A.
snock, or neart issuur	r complications that e. List only one cau	coused the de se on each line	eth. Do n	ot enter the mo	de of dying, suc	h se cerdi	sc or resp	Indicate Ind	rest,	Approximate Interval Between
disesse or condition	VIA	1-1.	1	1. 1.						Onset and Death
resulting in desth)	A DUE TO	IOR AS A CONSE	DUENCE	tarpo	27					dey
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	At Chen	sc/erc	LE	Cu	Lovas	euke	r Pe	ECAS	ec	30 years
STATE OF MART CARD OF DEATH MEND OF DEATH REG NO. 1. DECERDITE MARE (FIRST, MASSE, LLAST) MARY A SOCIAL BECUMY NUMBER A SOCIAL BECUMY NUMBER A SOCIAL BECUMY NUMBER A SOCIAL BECUMY NUMBER A SOCIAL BECUMY NUMBER A SOCIAL BECUMY NUMBER A SOCIAL BECUMY NUMBER A SOCIAL BECUMY NUMBER A SOCIAL BECUMY NUMBER A SOCIAL BECUMY NUMBER B SWITHSPLACE (Solar of Prospire) B SWITHSPLACE (Solar of Pros										
PART Other significent conditions of the conditi	one contributing to	ecker	esulting i	n the underlying	g ceuse given in	Part I.	PERFO	RMED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE
DID TOBACCO USE CON	TRIBUTE TO CA	USE OF DEA	TH YE	S I NO I	LINCEPTAI	N X				1 TES 2 NO
25. WAS CASE REFERRED TO MEDICAL					, OITCERIAI	- Val				
				OTHER:	a & Danida	• 🗆 🗪	(Caralla)			
27. MANNER OF DEATH	28a. DATE OF		28b. TIM				(Specify)	NJURY OC	CURED	

9

Netural
Accident
Suicide

M 1 YES 2 NO 28e. PLACE OF INJURY — At home, term, atreet, factory, office building, atc. (Specify)

28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only CERTIFYING PHYSICIAN:

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Could not be

32 REGISTRAR'S SIGNATURE

SETER Collect, DO 1308 EUSINGS UTE UN ENJEUN-

					CERTI	FICATE OF	DEATH		REG. N	0.		
	1. DECEDENT'S NAME (First, Midd Marion	marie Marie	C =					2. DATE	OF DEATH	DAY	TEAR	A TIME OF DEATH
4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIR								OF BIRTH	20	A. BIRTY	TO ACE COME IN COMMO	
	220-09-7132		1 - M 2 K F		73 YRS.	MONTHS DAYS	HOURS MIN.	(Mon	th, Day, Year)	1921	Count	ny)
	9a. FACILITY NAME (If not institution	on, give stre	et and number)		, ,	96. CITY, TOWN	OR LOCATION OF	DEC.	,),]		NTY OF D	PEATH
CTOR	311 E. Locust St. Union Bridge Carroll											
Ш		COUNTY			10c, C	CITY, TOWN OR LOCA	TION					10d. INSIDE CITY
DIR.	Maryland	C	arroll				n Bridge					1 X YES 2 NO
RAL		De. STREET AND NUMBER					r. ZIP CODE			12/5		WHAT COUNTRY?
FUNE	311 E. Locus		12. WAS DECEDEN	NT EVER IN	U.S. ARMED	13 WAS DE	21791 CENDENT OF HISP	ANIC ORIGI	M2 (Specify)		J.S.A	E — American Indian.
BY FI	1 Never Married 2 Marri 3 X Widowed 4 Divorced	2 NO	If yes, s	pecify Cuben, Mexi S 2 X NO Spe	can, Puarto				k, White, etc.			
0		ITIO EDUIO	71011									White
ETE	(Specify only high	DENT'S EDUCATION lighest grade completed) 2) College (1-4 or 5 +)			(Give kind o	"S USUAL OCCUPATI of work done during m use retired.)		161	. KIND OF B	IUSINESS/INI	DUSTRY	
PLE	Elementary/Secondary (0-12)		College (1-4 or 5	+)	beauti	cian o	wner/ perator		hea	antv s	a100	
COMPL	11 beautician öpërator beauty salo 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname)									01.01.		
BE (D. Roy Grossnickle Amanda Fleming											
5	19e. INFORMANT'S NAME (Type/Pr	rine)				NG ADDRESS (Street						
	Lana J. Sixx 7988 Schooner Ct. Frederick, MD 2170 2004/METHOD OF DISPOSITION 2004-PLACE AND DATE OF DISPOSITION (Name of DATE 2004-LOCATION - City of T											
	1 ABurial 2 Cremation 3 4 Donation 6 Other (Spec		al from State	ceme	etery, crematory of	r other place)		1				
	4 Donation 6 Other (Specify) Mountain View Cemetery 6/25 Union Bridge 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY D. D. Hartzler 8											e. MD
	1 / 1/ .					and the same of	NO ADDRESS OF	ACILITY T) D T	I 4 - 1	0	
	atharine	-(V	Xa.	Ble			Union	l Bridg	ge, MD)		
	23. PART I. Enter the disease shock, or heeft is iMMEDIATE CAUSE (Finel disease or condition resulting in death)	lea, or co fellure. Li	at only one car	AR (the death. Do	o not enter the m	Union	Bridg	ge, MD diec or rea)		Approximate interval Between
TION	immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	fellure. Li	DUE TO	AR (OR AS A	el Nov	o not enter the m	Union ode of Oxlog, sa	Bridg	ge, MD diec or rea)		Approximate interval Between
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AL CERTIFI	shock, or heart is immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	a. a. d.	DUE TO	O (OR AS A	CONSEQUENCE	OF):	Union ode of dying, se	Bridg	ge, MD diec or rea	npiratory ar	reat,	Approximate interval Betwoods and De Conservation of Cause of Death?
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ED BY PHYSICIAN: MEDICAL CERTIFI	shock, or heeft immediate cause. Enter Undertying in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant or EXAMINER? 1 YES NO 27. MANNER OF DEATH Natural 5 Pendi 2 Accident Invest 3 Suicide 6 Could detart 29a. CERTIFIER (Check only 1 CERTIFYIN)	b. c. d. onditions DICAL Hing eligetion d not be milned NC PHYSICAL EXAMINER:	DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO AN: To the best of	O (OR AS A O (OR AS A O (OR AS A O (OR AS A O (OR AS A O (OR AS A O (OR AS A O (OR AS A O (OR AS A O (OR AS A O (OR AS A O (OR AS A O (OR AS A O (OR AS A O (OR AS A O (OR AS A O (OR AS A O (OR AS A O (OR AS A O (OR AS A	CONSEQUENCE CONSEQUENCE CONSEQUENCE CONSEQUENCE at not resulting attent 3 □ DOA 280. T	OF): OF):	Union ode of oxing, sa ode of oxing, sa ode of oxing, sa ode of oxing, sa ode of oxing, sa ode oxing	n Part I. Check only o 26f. LOC City use to the case time, determined time, determined time, dete	24a. WAS j. PERF. 1 YES CATION (Streen or Town, State use(a) and m	AN AUTOPSY ORMED? 2 NO NOTE and Number to and due to the and due	24b CURED r or Aural i	Approximate interval Betw Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do

32. REGISTRAR'S SIGNATURE Develor Ravall

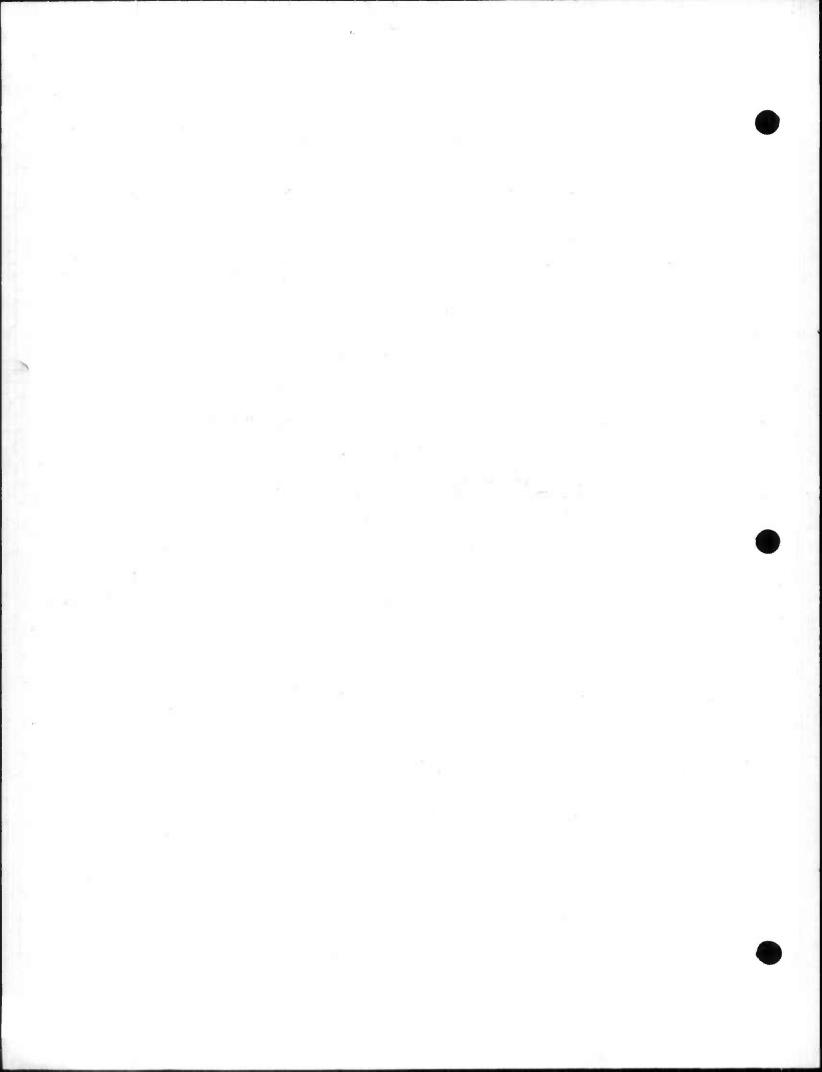
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4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS 191-07-0887 1 TM 2 F 76 Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number DIRECTOR Calvert Memorial Hospital 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION Maryland St. Mary's Mechanicsville permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE funeral director, page 5 should be detached for use as the burial-transit 1370 Claire Circle 20659 Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 1 Never Married 2 Married BY 3 Widowed 4 Divorced 1944-1966 COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION secify only highest grade complete (Sp Elementary/Secondary (0-12) College (1-4 or 5 +) 12 Chief Petty Officer 17, FATHER'S NAME (First, Middle, Last) John Sepety BE notified 19a, INFORMANT'S NAME (Type/Print) 2 Michael J. Sepety 9 20e. METHOD OF DISPOSITION

15 Buriel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of must 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE VICENSER examiner Mark G. Brohawn M00053 executed within T4 hours after do in and completely filled in by the to burial, cremation, or removal. medical shock, or heert fallure. List only one cause on each line. IMMEDIATE CAUSE (Final the disease or condition resulting in death) DUE TO (OF AS A CONSEQUENCE OF) event. traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, lesding to immediate attending physician ntal Hygiene prior to death certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 the atter Injury. MEDICAL been signed by th 1) rection. апу shows aboute PHYSICIAN: has be 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) OR ATTENDING PHYSICIAN; The HOSPITAL: certificate t OTHER: 1 YES 2 HO itient 2 ER/Oulpatient 3 DOA 10 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT with t marked, 1 Natural 5 Pending 1 YES 2 NO BY After Investigation 2 Accident 3 Sulcide 28e. PLACE OF INJURY — Al home, farm, streel, factory, office building, etc. (Specify) 28 Is Could not b DIRECTOR: / 4 Homicide COMPLET Hem 29a. CERTIFIER FUNERAL (HOSPITAL -TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 29b. SIGNATURE AND TITLE OF CERTIFIER BE

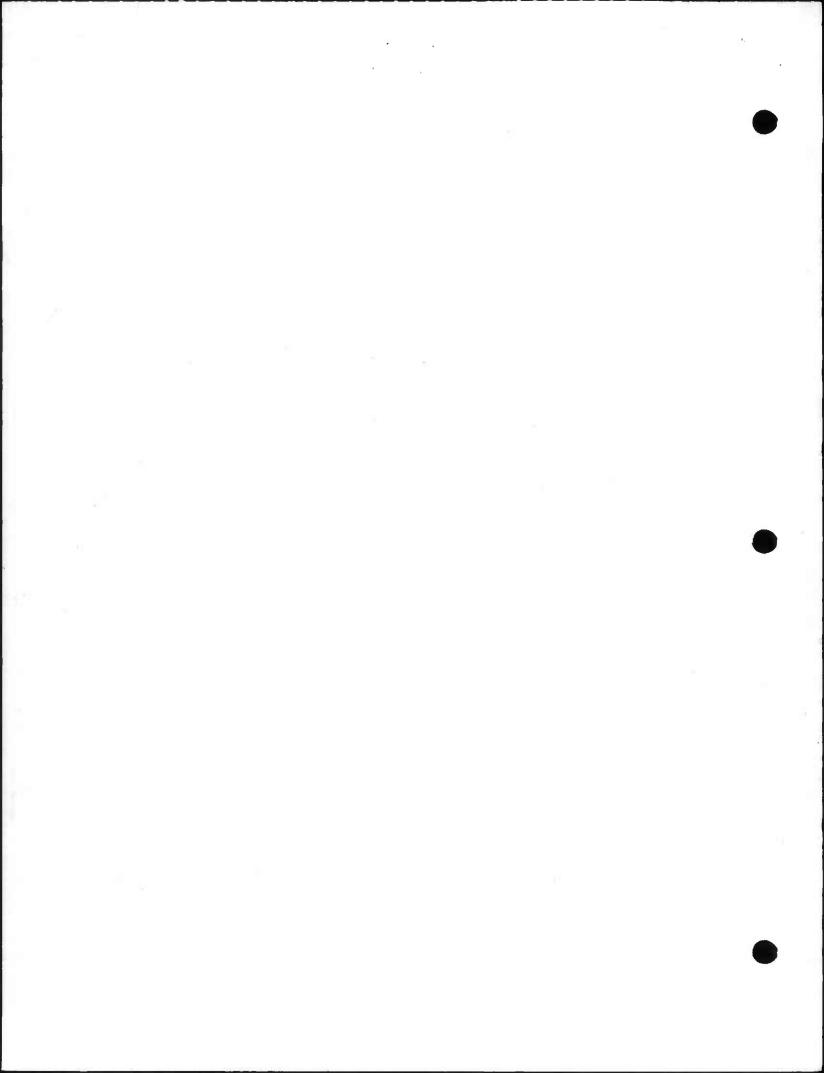
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH June 28, 1995 Michael Sepety 0802 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) Feb. 3. Scranton. PA 1919 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Prince Frederick Calvert 10d. INSIDE CITY 1 TYES 2 XNO 10g. CITIZEN OF WHAT COUNTRY? USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. White 16h. KIND OF BUSINESS/INDUSTRY US Navy 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Palischak 19b. MAJLING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1370 Claire Circle, Mechanicsville, MD 20659 20c. LOCATION — City or Town, State DATE emetery, crematory or other place)
Maryland Veterans' Cem. 7 7-3 Cheltenham, MD Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20601 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, Approximate Interval Between Onset and Death Corebro Vascula 1-aw weeks PART II. Other significent conditions contributing to death but pot resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 4 Nursing Home 5 Residence 8 Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as steted. 2 MEDICAL EXAMINER: On the besia of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER Toumshi m D. Alland 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (1) po. Print) Dr. Anwar Munshi Prince Frederick, MD 20678 31. DATE FILED JUN 2 9 1995 32. REGISTRANS SIGNATURE
JULYA WHUMBER REVOLUL



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		1. DECEDENT'S NAME (First, Middle, Lest)					2. DATE OF DEAT	гн		TIME OF DEATH	-
		Harry Edward Ti	ruitt				6	21	95	5:45 P	N
Þ		218-12-1531	[X M 2 □ F	n yrs. last birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTI (Month, Day, Vo. 3 / 21 / 1	ar)	Country)	CE (State or Foreign	
3 should	oc	9a. FACILITY NAME (If not institution, give stree	,			OR LOCATION OF D	EATH		Y OF DEATH		P M Foreign TY NO P Indian, E Imata Batween and Death FINDINGS OR TO FOUND NO A started,
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Sage	REC	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCA	TION			10d. INSIDE CITY		
# 6	DIR		orcester		Berlin				1[YES 2X NO	
ozo physician. burial-transit permit. Pages 1,	FUNERAL	10e. STREET AND NUMBER	D.D.		10	1. ZIP CODE		10g, CITIZE		COUNTRY?	
cian. -trans	N N	7809 Libertytow	N KD 2. WAS DECEDENT EVER IN	III ADMED	12 WAS DE	21811	NIC ORIGIN? (Specif		USA		_
	B⊀	1 Never Married 2 X Married 3 Wildowed 4 Divorced	FORCES? 1 TYES	2 NO	If yes, sp		an, Puerlo Rican, etc		Black, WI Specify:	white	
r attend use as	8	15. DECEDENT'S EDUCAT (Specify only highest grade cor		18a. DECEDENT'S	USUAL OCCUPATI	ON and working	16b. KIND O	F BUSINESS/INDU	STRY		-
A SE E	LET		College (1-4 or 5+)	IIIe. Do NOT us	se retired.)	ost or working					
the hospid detached once.	COMPL	17. FATHER'S NAME (First, Middle, Last)		Truck	Driver	I		Dil Co.			_
3 E E	U U	Minus Truitt					AME (First, Middle, Ma Dennis	aiden Surname)			
s should notified	m	19a, INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street		Route Number, City of	r Town, Stete, Zip C	ode)		_
2 5 5	임	Helen Marie Trui	tt				D Berlin		21811		
2 8		20a, METHOD OF DISPOSITION 1 Description 2 Cremetion 3 Remove	from Stata com	PLACE AND OATE	OF OISPOSITION (Na	anie of	OATE 20	c. LOCATION — CI	ly or Town,	Stata	_
Page 6 ma al director, a		4 Donation 5 Other (Specify)	R	iverside	Cemete		/24/95	Berlin,	MD		
death. Pag tuneral di k		21. SIGNATURE OF PUNERAL SERVICE LICEN	SEE		22. NAME A	ND ADORESS OF FA	Bur	bage Fu	neral	Home	
2 2 2 3	Ш	11 TXK 20	utal		108	William:	s St. Be	rlin, ME	21	811	
3		23. PART if Enter the diseases, or con ahock/or heart failure. Lis	nplications that caused t only one ceuse on ea	the deeth. Do inch ilne.	not enter the mo	ode of dying, aud	ch aa cardiec or i	reapiratory arres	it,		n
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and com o bunial,	z				,				į	~	
. 8 ° 0 F	CATIO	Sequentieily list conditions, If any, leading to immediate	OUE TO (OR AS A	CONSEQUENCE O	F):						
		cause. Enter UNDERLYING CAUSE (Disease or injury	OUE TO (OR AS A	CONSEQUENCE OF	F)·						_
	RTIFI	that initiated eventa resulting in death) LAST	10 300000		. , .				į		
2 2 2 3	CE	PART II. Other aignificent conditions of	contribution to death by	at not reculting	in the underlyin	a across alvest la	Post I as un				
2 2 2	CAL	orial significant conditions of	ontilibuting to destri bi	ze not resulting	in the underlyin	g cause given in	PEI	S AN AUTOPSY RFORMED?	AVA	LABLE PRIOR TO	5
w requires that been signed to the of Health a shows any	MEDIC						1 D YE	S 2 NO	OF	DEATH?	
	AN: N	DID TOBACCO USE CONTRIB	SUTE TO CAUSE O	F DEATH YE	S IZ NO [UNCERTAI	NO] '') TES 2 ∐ NO	
has has	SI	25. WAS CASE REFERRED TO MEDICAL		8. PLACE OF DEA	TH (Check only one)				1		_
SICIAN: The certificate the State	YSICI	1 D YES 2 NO 1	OSPITAL: Inpatient 2 ER/Outpo	itlent 3 DOA	OTHER: 4 Nursing Horn	e 5 🖪 Realdence	8 Other (Specify,)			
NG PHYSIC fler this ce eath with the	РНҮ	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM INJ	URY WO	JURY AT DRK?	28d. DEŞCRIBE H	OW INJURY OCCU	RED		
After After death	β	2 Accident Investigation	28e. PLACE OF INJURY	— At home, farm, r	"	YES 2 NO	201 LOCATION (S	treet and Number or	Ocean Country	Attento	_
OR ATTENDING PHYSICIAN: DIRECTOR: After this certifica hours after death with the St item 28 is marked, or it	ETED	4 Homicide determined	building, atc. (Speci	TV)			City or Town, S	State)		Number,	
A Z Z	COMPLET		N: To the beat of my knowle								
HOSPITAL FUNERAL within 72 t		29b. SIGNATURE AND TITLE OF CERTIFIER	on the bears of exemination	and/or investigatio	n, in my opinion, d						
E E E	BE	250. SIGNATURE AND TITLE OF CERTIFIER	RIC	_		29c. LICENSE NU		29d. DATE S	//	nth, Day, Year)	
P P 2 M	임	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETEO CAUSE OF OEA	TH (ITEM 27) (Type,	Print)	H442	0 >	6/	22/	/'	
		9733 Hezl	Rus D	live	Be	1.1.V	40				
	5	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA								_
		JUN 23 1995	John Bender	m-Randall							



THE FUNERAL DIRECTOR: After this certificate been requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	Pon	
00	within 24	
K 587	executed	
5	2	
.C.	certificate	
, L	death	
	the the	
2	that	
Z L L	requires	
_	34	
4	The	
7	PHYSICIAN:	
DIVISION OF VITAL RECORDS, P.O. BOX 68/60	THE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hour	
5	TO T	
1	đ.	

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	HEGISTHAH		CERTIF	ICATE O	PUEATH	REG. NO					
	1. DECEDENT'S NAME (First, Middle, Last)	ADTUUD TI	LEDY				AY YEAR				
	4. SOCIAL SECURITY NUMBER	ARTHUR TI	LLCKY (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	JUNE 18		THPLACE (State or Foreign			
1	238-46-7904 9a. FACILITY NAME (If not institution, give stre	1 🗽 M 2 🗆 F	68 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) MARCH 22,	1927 NC	RTH CAROLINA			
OR	PRINCE GEORGE'S HO			9b. CITY, TOW	GEORGE'S						
ᇈ	RESIDENCE OF DECEDENT 100. STATE 100. COUNTY 100. CITY TOWN OR LOCATION										
DIRECTOR	MARYLAND PRINCE	GEORGE'S		Y, TOWN OR LO		10d. INSIDE CITY LIMITS? 1 X YES 2 NO					
FUNERAL	100. STREET AND NUMBER 4007 73rd A	VENUE			20784		WHAT COUNTRY?				
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 M Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	2 X NO	If yes,	ECENDENT OF HISPAI apecify Cuban, Mexica ES 2 XNO Specifi		Bia	CE — American Indian, ick, Whita, etc. pc/ly: BLACK			
입	15. DECEDENT'S EDUCA	TION	16a. DECEDENT'S	USUAL OCCUPA	TION	16b. KIND OF BU	SINESS/INDUSTRY				
COMPLETED	(Specify only highest grade or Elementary/Secondary (0-12) 9th	College (1-4 or 5+)		work done during se retired.) IFT OP:		1	PVT.				
0	17. FATHER'S NAME (First, Middle, Last)		-		18. MOTHER'S NA	ME (First, Middle, Maiden	Surname)				
BEC	HENDERSON 7	TILLERY			GEOR	GANNA CLAR	K				
10 8	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	t and Number or Rural	Route Number, City or Tow	n, State, Zip Code)				
F	DUDREY E. PLATT/	/ DAUGHTER	4007	73rd A	VENUE HYA'	TTSVILLE,	MARYLAND	20784			
	20a. METHOD OF DISPOSITION 1 ☐ Buriel 2 ☐ Cremetion 3 ☒ Remov 4 ☐ Donation 5 ☐ Other (Specify)	ral from State C6	b. PLACE AND DATE Of metery, cremetory or of STATON ME	ther place)	Name of CEMETERY		CATION — City or				
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE /	JIATON III			S'FUNERAL		At IVO			
- 1	- Juawana	A. D.	axtor	1 747	1 LANDOVE	R ROAD LAN	DOVER, M	ARYLAND20785			
	23. PART I. Enter the diseeses, or co shock, or haert failure. Li	mplicetions that cause st only one ceuse on	ed the death. Do n	ot entar tha	noda of dyling, suc	h as cardiac or respi	ratory arrest,	Approximata Interval Between			
	resulting in death) s,	1606	ne one	rayes	inclia						
	DUE TO (OR AS A CONSEQUENCE OF):										
o l	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury) Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury)										
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	C	ardio 3	eene	Shoe	K					
Ĭ.	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS	A CONSEQUENCE OF	7;	* × ×	2	0 0				
F	resulting in deeth) LAST	Mo	st like	ly 1	tente "	yo card	ou rugery	lu			
- 11	PART II. Other significent conditions	contributing to death	hut not consistent	V							
DICAL		neumenia				Part I. 24a, WAS AN PERFOR		b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO			
		erdionejo				1 [] YES 2	NO	COMPLETION OF CAUSE DF DEATH?			
Σ	DID TOBACCO USE CONTRI	BLITE TO CALVE	DE DEATH VE		Analme			1 TYES 2 NO			
N N	25. WAS CASE REFERRED TO MEDICAL	BUTE TO CAUSE (26. PLACE OF DEAT		UNCERTAIN						
PHYSICIAN: M		HOSPITAL:		OTHER:							
Ě	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIMI	E OF 28c, I	MURY AT	8 U Other (Specify) 28d. DESCRIBE HOW II	NJURY OCCURED				
BY P	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ		VORK? YES 2 NO						
COMPLETED E	3 Suicide 8 Could not be determined	28e. PLACE OF INJUR building, etc. (Spe	Y — At home, tarm, s ocify)	treet, factory, of	ice	28f, LOCATION (Street a City or Town, State)	nd Number or Rurel	Route Number,			
۳	290. CERTIFIER 1 X CERTIFYING PHYSICI	AN: To the best of my know	windon double occurre	ed at the time de	to and place and due	4. 4b					
Š	(Check only one) 2 MEDICAL EXAMINER:							(e) end manner sa stated.			
	296. SIGNATURE AND TITLE OF CERTIFIER	7			29c. LICENSE NUN			La Company			
TO BE	121	Julag	mo		D247		DATE SIGNE	18-95			
	Dr · RAVINOER	COMPLETED CAUSE OF D	TAG	Print) 61	32 La	udover 1	Rd de	785			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG				7					
	JUN 21 1995 July	d'avilentan	tall								

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retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3 should

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DIRECTOR

FUNERAL

BY

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COMPL

2

3 Suicide

4 Homicide

BOX 68760 C DIVISION OF VITAL RECORDS.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Mileos lurner 1535 995 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 12-31-28 DAYS HOURS MIN. 577-32=8881 1 X M 2 - F 66 N.C 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH SHADY GROVE HOSPITAL GAITHERSBURG MON'TGOMERY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MONTGOMERY GERMANTOWN XX YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20876 21312 GLENDEVON COURT U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? YES YES 2 NO IF YES, GIVE WITH OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yee, specify Cuban, Maxican, Puerto Rican, etc.)
1 □ YES ⊕ ⊕ NO Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married Specify: BLACK 3 Widowed 4 Divorced KOREAN 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b, KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) CHAUFFER U.S.GOVT 8th 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname)

COMPLETED MILEOS DAVIS BE ANNIE POWELL 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MYRNA TURNER 21312 Glendevon CT.Germantown MD20876 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State cemetery, crematory or other place) S.S MD. PARKLAWN CEMETERY 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MODERN FUNERAL HOME 3821 14th ST.N.W.D.C. 23. PART t. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final **Onset and Death** disease or condition MYOCAR AIAL
DUE TO (OR AS A CONSEQUENCE OF) resulting in death) MINH ingetes CERTIFICATION Sequentially list conditions, if sny, lasding to immediate DUE TO (OR AS A CONSEQUENCE OF) cause. Enter UNDERLYING 1) RONARY CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 - NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL:
1 | Inpatient 2 | PER/Outpatient 3 | DOA OTHER: g Home 5 - Residence 6 - Other (Specify) 26a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural
Accident

М 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify)

1 YES 2 NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

29d. DATE SIGNED (Month, Day, Year)

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Grove Advertist Kespital AUID 6. Snoun

Sharly

296, SIGNATURE AND TITLE OF CERTIFIER

31. DATE FILED (Month, Day, Year)

6 Could not be

determined

DHMH-16 Rev 1/89

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

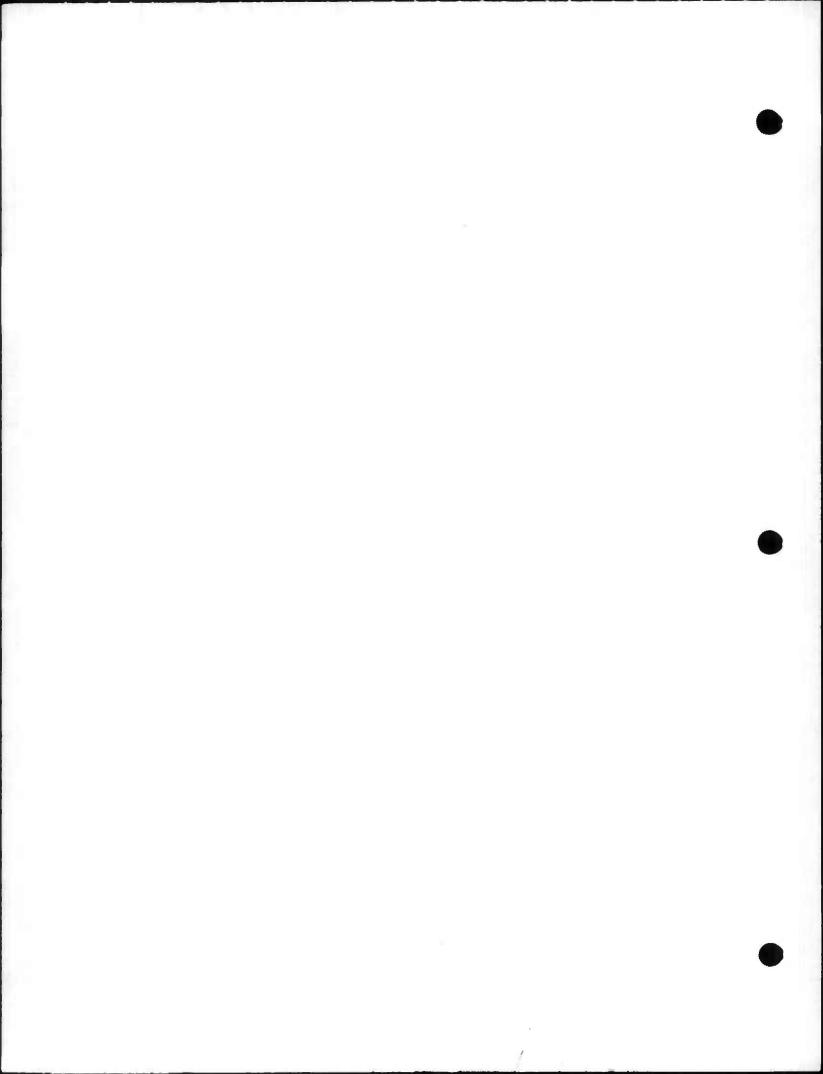
FOR 1 . STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR			CERTIF	ICATE	OF	DEATH	F	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) ERIC ALFRE	D	TERRE	т.т.	2. date of death JUNE 17, 1955						VEAD	3. TIME OF DEATN 12:48 PM
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs		IF UNDER	1 YEAR	IF UNDER 24 HRS.	7. DATE OF 1		, , 1		LACE (State or Foreign
	577-68-6064 9a. FACILITY NAME (If not institution, give s	1XXM 2 F	45	YRS.	MONTHS	DAYS	HOURS MIN.	(Month, Da 2-3			Wash	., D.C.
0 E	1410 EARLY OAK					L OAKS	EATN		1.0	NCE	GEORGES	
ទួ	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	Y		10c, CIT	10c. CITY, TOWN OR LOCATION 10d, INSIDE							
PIB	MD. P.G	3.		Aldephi							LIMITS?	
FUNERAL DIRECTOR	100. STREET AND NUMBER 1836- Metzerott	Road			10f. ZIP CODE 20783					1	U.S.A	HAT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 X Married 3 Divorced	T EVER IN U.S. YES 2 MR OR DATES	W NO		f yes, sp	ENDENT OF NISPAR ecity Cuben, Maxica 2 X NO Specifi	n, Puarto Rica	pecify Yea n, etc.)	or No-	Specify	- American Indian, White, atc.	
COMPLETED	16. DECEDENT'S EDU (Specify only highest grade		16a	DECEDENT'S	work done o	CCUPATE	ON est of working	16b. KIN	ID OF BUS	INESS/IN		acx
APLE	Elementary/Secondary (0-12)	College (1-4 or 5	-)	Cons	truc	tior			N/	Ά		
ğ	17. FATNER'S NAME (First, Middle, Last)						16. MOTNER'S NA	ME (First, Midd	le, Maiden	Sumame)		
BE	William J. T	errell		40b MAN INC	4000500		Kat	hleen				
2												
	Revonda Terrell 200. METNOD OF DISPOSITION		00h DI 4	CEANDDATE			ott Rd.,				O783 City or Tow	
	1 Surial 2 ☐ Cremation 3 ☐ Ram 4 ☐ Donation 8 ☐ Other (Specify)		an materia	crematory or o	46			6/23			er, MD	
	21. SIGNATURE OF UNERAL SERVICE LIC	CENSEE	lacks	d	1	Hack	obaddress of fa cett's Fu Upshur	neral			Inc.	
											interval Between Onset and Death	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST											
GE		d										
MEDICAL	PART ii. Other algnificent condition	ot resulting	in the un	g ceuse given in		PERFORMED?		WERE AUTOPSY FINDINGS WARLABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? DE YES 2 NO				
	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF D	EATH YE	S 🗆 N	NO [UNCERTAIL	V 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		LACE OF DEA	OTHER							
∑ ≥	XYES 2 NO 27. MANNER OF DEATN	1 Inpatient 2			4 🗌 Nuri				_			
ВУ РН	1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF (Month, D FOUND: 6/	ay, Year)	286. TIM FOUN	(URY		URY AT PRK? YES 2 1 NO	UNKNOW!		JURY OC	CURED	
	3 Suictde 8 Could not be determined	F INJURY — A atc. (Specify)		street, facto	ory, offic	•	281. LOCATIO City or To CHAPEL	wn, State)	1410	EARL O.	AKS LANE	
COMPLETED	29a. CERTIFIER 1 CERTIFYING PNYSI (Check only one) 2 XXeDICAL EXAMINE	CIAN: To the best of R: On the basis of a:						to the cause(s) and man	ner as sta	rted,	
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER O.C.M.E 296. DATE SIGNED (Month, D JUNE 18, 3 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)										Month, Day, Year) .8, 1995	
	- A	GHT M	D 111	Peni	ı St	ree	t, Balt	imore	, M	ary]	land	21201
	JUN 21 1995 Jul		R'S SIGNATUR									

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DALLINORE, MARTLAND	after death. Page 6 may be retained by the hosp	by the funeral director, page 5 should be detached	cal examiner must be notified at once.
Service Control of th	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filled in by the funeral director, page 5 should be detached filled in by the funeral director, page 5 should be detached filled in by the funeral director, page 5 should be detached filled in by the funeral director, page 5 should be detached filled in by the funeral director, page 5 should be detached filled in by the funeral director, page 5 should be detached filled in by the funeral director, page 5 should be detached filled in by the funeral director, page 5 should be detached filled in by the funeral director, page 5 should be detached filled in by the funeral director, page 5 should be detached filled in by the funeral director, page 5 should be detached filled in by the funeral director, page 5 should be detached filled in by the funeral director filled in by the funeral	be lieu within 12 hours are used with the 25ste bett. Or regult and welled righer profit of burlay, crematon, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,

	1 - STATE OF MARYLE REGISTRAR	AND / DEPAR CERTIFI	TMENT OF H	IEALTH AND I	MENTAL HYGIEN						
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3, TIME OF DEATH				
	ADA TATE				JUNE 14,	1995 YEAR	7:30PM M				
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (IF UNDER 24 HRS.	7. DATE OF BIRTH		HPLACE (State or Foreign						
	219-54-8802 ¹□ M 2 🕅 F	82 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year)	Coun	try)				
	9e. FACILITY NAME (If not institution, give street and number)	62	9h CITY TOWN (OR LOCATION OF DE		pr. 24, 1913 Virginia					
DIRECTOR	Prince George's Hospital Cent	er	Chever!		AIH		George's				
	10e. STATE 10b. COUNTY		10d. INSIDE CITY								
ā	Maryland Prince George's	Col	mar Mano	or			LIMITS?				
A	10e. STREET AND NUMBER		101	ZIP CODE		WHAT COUNTRY?					
FUNERAL	3817 Newark Road			20722		United	States				
3	11. MARITAL STATUS 12. WAS DECEDENT EVER IN		13. WAS DEC		IC ORIGIN? (Specify Yes	or No- 14, RAC	E - American Indian				
	1 Never Merried 2 Merried FORCES? 1 YES		2 X/NO If yes, specify Cuban, Mex			Blec	k, White, etc.				
B	3 Widowed 4 Divorced		1 123	2 M No specify		Spec	White				
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	160. DECEDENT'S	ISUAL OCCUPATION	ON	16b. KIND OF BUS	SINESS/INDUSTRY					
<u> </u>	Elementary/Secondary (0-12) Coflege (1-4 or 5+)	life. Do NOT use	ork done during mo retired.)	st of working							
릴	6	Housewife				Home					
ō	17. FATHER'S NAME (First, Middle, Last)					Surneme)					
	Harry Trent			-545-0724 [77-4]	. Pavne						
BE	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING	ADDRESS /Street a		loute Number, City or Tow	on State 7th Code)					
2	Margaret Smith										
	20e. METHOD OF DISPOSITION	PLACE AND DATEO			man Manor,						
- 1	1 T Burtal 2 Cremation 3 Removal from State Com-	etery cremetory or off	er nlecel								
Fort Lincoln Cemetery 6/19/95 Brentwood, Maryland											
- 1	Fort Lincoln Funeral Home, Inc.										
	· Olymp				rg Rd., Bi		MD 20722				
	23. PART I. Enter the diseases, or complications that caused	the deeth. Do no	ot enter the mo	de of dying, auch	as cerdiec or respi	iratory arrest,	Approximete				
ahock, pr heart failure. List pnly one cause on each line. IMMEDIATE CAUSE (Final											
1	disease or condition										
i	resulting in death) a. MAILVE DUE TO (OR AS A	CONSEQUENCE OF	HOUCA	re re	COUNT		NVVGS				
-											
CERTIFICATION	Sequentially list conditions, If any, leading to immediate										
¥ I	cause. Enter UNDERLYING		į l								
E	CAUSE (Disease or injury thet initiated events DUE TO (OR AS A	CONSEQUENCE OF)	:								
E	resulting in deeth) LAST										
빙	d										
A	PART ii. Other significant conditions contributing to death but	it not resulting in	the underlying	ceuse given in l			. WERE AUTOPSY FINDINGS				
일					PERFOR		AMAILABLE PRIOR TO COMPLETION OF CAUSE				
南川					_	/ ····	DF DEATH? 1 YES 2 NO				
<u> </u>	DID TOBACCO USE CONTRIBUTE TO CAUSE OF	F DEATH YES	□ NO 🖾	UNCERTAIN			1 129 2 NO				
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL	8. PLACE OF DEATH		OTTOLKIAII							
잃	EXAMINER? 1 ☐ YES 2 NO 1 ☐ Impatient 2 ☐ ER/Outpa		OTHER:								
¥∥	27. MANNER OF DEATH 280. DATE OF INJURY	28b. TIME		5 Rasidence	26d. DESCRIBE HOW II	HIER COOLINGS					
	1 Natural 5 Pending (Month, Day, Year)	เทาก	RY WO	RK?	200. DESCRIBE NOW II	NJUHY OCCURED					
à	2 Accident Investigation 3 Suicide S Could not be 28e. PLACE OF INJURY	44 5 4		ES 2 NO							
	3 Suicide 6 Could not be 4 Homicide determined	Ty)	reet, rectory, office	'	26f. LOCATION (Street e City or Town, State)	and Number or Rural i	Route Number,				
COMPLETED											
릴Ⅱ	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge of the control of the best of the center of the best of the center of the cen										
8	one) 2 MEDICAL EXAMINER: On the basis of examination	end/or investigation	, in my opinion, de	eath occured at the t	ime, date and place, and	d due to the cause(e	e) end menner se stated.				
	296. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUM	BER I	29d. DATE SIGNED	(Month Day Year)				
8	W L 2 NOT				874		5-91				
유	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type. I	Print)				-				
	S.M. NAYAR, NO. 3717 -	38" N	V . COT	TAGE CI	M. MD	2072)				
-			- 117		1 2	10,					
	JUN 21 1995 Julia Durillar hard	11					-				
	2011 ET 1220										

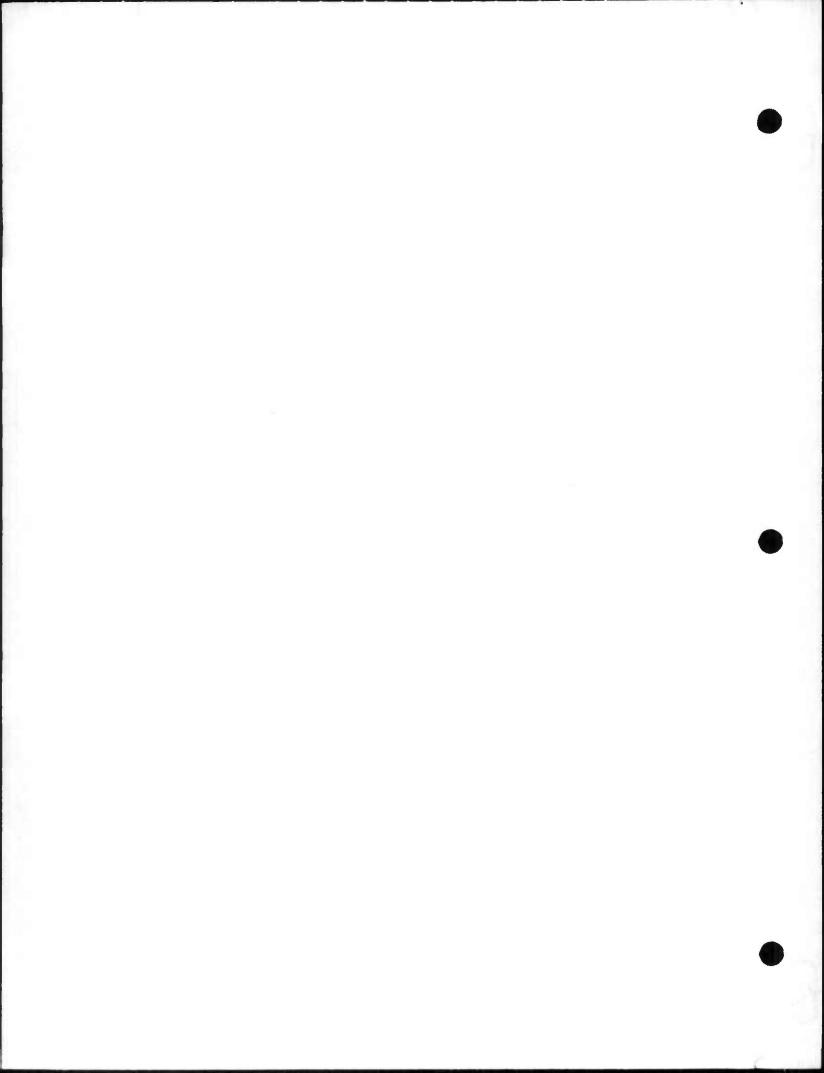


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DIVISION OF VITAL RECORDS, P.O.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 10 miles of the burial-transit permi	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	(MEDOTINE) is senseted as them 29 shows about below to the modified and the modified as
9 TE	O THE	e filed	MDOC
F	E	A	=

_	FOR STATE REGISTRAR	STATE OF MARYLAI		TMENT OF H		MENTAL HYGIEN	E				
	1. DECEDENT'S NAME (First, Middle, Last)	7	arvei	r		2. PATE OF DEATH DAY YEAR 3. TIME OF DEATH MONTH DAY 19 9'S 114 M					
	4. SOCIAL SECURITY NUMBER 416-09-4541	1# M 2 □ F 79	yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH 8. BIRTHPLACE (State or I					
TOR	90. FACILITY NAME (If not institution, give 408 Possum Court	street and number)		Capital H	eights	Prince Georges					
DIRECTOR		Georges	10c CITY	ital Heig	ION ICS			10d. INSIDE CITY LIMITS? 1 # YES 2 NO			
FUNERAL	100. STREET AND NUMBER 408 POSSUM COURT				ZIP CODE 20743			N OF WHAT COUNTRY?			
₽	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 1 YES	2 NO		ENDENT OF NISPAI Icity Cuben, Mexica 2 # NO Specifi	or No — 14	I. RACE — American Indian, Black, White, etc. Specific Black				
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondery (0-12)	completed) College (1-4 or 5+)	6a. DECEDENT'S L (Give kind of w life. Do NOT use		N st of working	Private	SINESS/INOUS	TRY			
111	17. FATHER'S NAME (First Middle Last)				16. MOTHER'S NA Elizabeth	ME (First, Middle, Maiden 1 Foster	Surname)				
TO BE	19e. INFORMANT'S NAME (Type/Print) Ceneva Tarver		408 Poss	address (Street e	nd Number or Rural pital Heig	Ploute Number, City or Town phts, MD 207	n, Stata, Zip Co 43	ode)			
	20s. METHOD OF DISPOSITION 1										
	21. SIGNATURE OF FUNDINAL BETWICE UCENSEE 22. NAME AND ADDRESS OF FACILITY Bianchi Funeral Service 3718 22nd Street NE/ Washington, DC 20018										
pane and month	23. PART I. faster the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, ahock, or haert failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) OUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b									
MEDICAL C	PART II. Other significent condition	na contributing to death but	not resulting in	n tha undarlying	cause given in	Part I. 24a. WAS AN. PERFOR 1 TYES 2	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL		DEATH YES	NO 🗆	UNCERTAIN	N D		1 YES 2 NO			
PHYSICIAN:	EXAMINET?	HOSPITAL: 1 Inpetient 2 ER/Outpatic		OTHER:	5 D Residence	8 Other (Specify)					
ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	IRY WOI		28d. DESCRIBE NOW IF	JURY OCCUP	REO			
2	3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF INJURY — building, etc. (Specify)	At home, term, at	reet, factory, office		281. LOCATION (Street a City or Town, State)	nd Number or	Rural Route Number,			
COMPLET		ICIAN: To the best of my knowled									
BE	SIGNATURE AND THE OF CERTIFIE		21		29c. LICENSE NUN			IGNED (Month, Day, Year)			
1	30 NAME AND ADDRESS OF PERSON WIN	19 COMPLETED CAUSE OF DEATH	1 (ITEM 27) (THOS.)	Print) 4 Surn 1	Ct. Co	Sav Milo	7074	8			
1	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATU	URE	11		1	1/0				



DIVISION OF VITAL RECORDS, P.O. BOX 68760

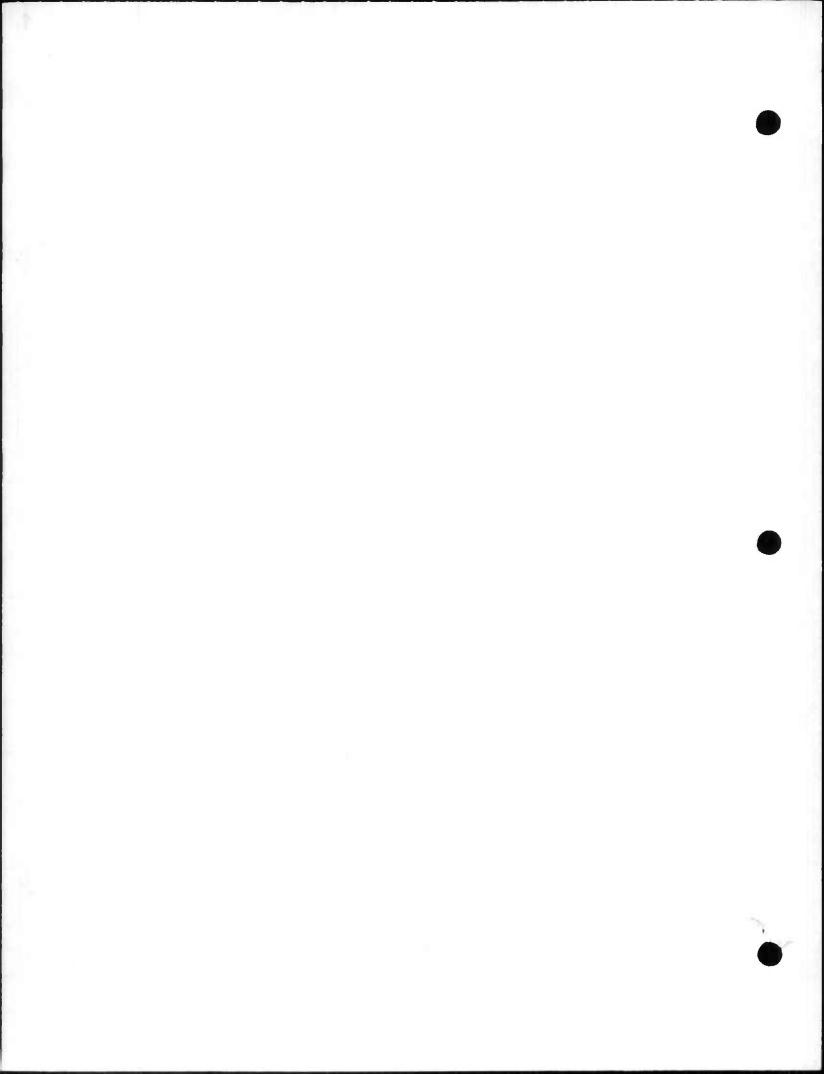
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTION After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	STATE OF MARYLAN				MENTAL	HYGIENE
		CERTIFICATE	OF DEAT	TH		REG. NO.
ME (First, Middle, Last)					2 DATE O	C DC ATN

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM	MENT OF I	IEALTH AND		GIENE G. NO.				
	1. DECEOENT'S NAME (First, Middle, Last)		04111110	AIL OI	DEATH	2. DATE OF DE		YEAR	3. TIME OF DEATH		
	HARRY THOM!					Juna 1	6, 199	25	12 50 a M		
		Gua De	MC MC	NTHS DAYS	# UNDER 24 HRS. HOURS MIN.	7. DATE OF BIF (Month, Day,	Year)	8. BIRTHP Country	LACE (State or Foreign		
	579-22-4326 19a. FACILITY NAME (If not institution, give stree		19	OUTY TOWAL	OR LOCATION OF O		51916		ester N.Y.		
DIRECTOR	Washington Adventi				oma Park			NTY OF OE			
	10a. STATE 10b. COUNTY			OWN OR LOCA	TION				10d. INSIDE CITY		
ا دَ	MD Princa	George's	·o.	owie.					LIMITS?		
A I	10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?										
£	4511 Oakview Lane				2071	=					
FUNERAL	11. MARITAL STATUS	2. WAS OECEDENT EVER IN	AS OECEDENT EVER IN U.S. ARMEO DRCES? 1 YES 2 NO If yes, specify Cuban, Mexica					14. RACE	- American Indian.		
8	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR D			ecify Cuban, Mexica 2 gr NO Specia		rtc.)	Black, Specify	White, etc.		
									White		
COMPLETED	15. DECEDENT'S EOUCAT (Specify only highest grade cor		(Give kind of work	done during mo	ON st of working	18b, KIND	OF BUSINESS/INC	DUSTRY			
ا ۲		College (1-4 or 5+)	ille. Do NOT use re	tired.)							
١	12th 17. FATHER'S NAME (First, Middle, Last)		Vendor				ivate				
						ME (First, Middle,					
4	Arthur Norman Thoms	oson	405 8847 710	ODESA (C	Lillia	c. The	moson				
2 ∥			1		nd Number or Rural		or Town, State, Zip	Code)			
	Regina C. Henson	- Lan	.PLACE AND DATE OF C		Ln. Bow		20715				
İ	1 Buriel 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	from State com	etery, crematory or other	place)		1	eoc. LOCATION —				
H	21. SIGNATURE OF FUNERAL SERVICE LICEN	see Jan	esapeake (remato	D AOORESS OF FA	Jun 17 IF	<u>eltsvil</u>	le. N	1D		
į					Jenkins		1 HOMA				
4	1		- "	7474	T.andows	T FO YE	22000000	_iviD	20785		
	23. PART I. Enter the diseases, or complications that Caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, ahock, or heart fellure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due to (or as a consequence of):										
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	MONIA, C CONSEQUENCE OF): CONSEQUENCE OF):				LURE				
5	resulting in deeth) LAST		CORONA	RY AR	PERY DI	CENCE					
3	PART II. Other aignificant conditions of	ontributing to death be					AS AN AUTOPSY	24b V	VERE AUTOPSY FINDINGS		
			VASCULA			P	ERFORMED?	6	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
	DID TOBACCO USE CONTRIB	SUTE TO CAUSE O	F DEATH YES	□ NO E	UNCERTAI			- '	YES 2 NO		
	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH (OTTOLKIAN	T L L					
3		OSPITAL:		THER:	5 Residence	• C Ont (C	4.1				
- Lucione	27. MANNER OF DEATN 1 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c, INJ WO	JRY AT RK?		HOW INJURY OC	CURED			
	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, stc. (Speci	— At home, farm, stree		ES 2 NO	28f. LOCATION (City or Town	Street and Number	or Rural Roo	ute Number,		
COMPLETED		N: To the best of my knowl	adda, daeth occurred e	the time date	and alone and due	40.00					
	(Check only one) 2 MEDICAL EXAMINER: C								and manner as stated,		
	29b. SIGNATURE AND TITLE OF CERTIFIER	Mas			AR 120				Aonth, Day, Year)		
1	30. NAME AND AODRESS OF PERSON WHO C	OMPLETEO CAUSE OF OE	ATH (ITEM 27) (Type, Prin	(1)					13		
- 10-	A.R. R20 810	10 Good 1 110	rk Road	#302	Tank-	MD	207	07			
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGNA	ATURE	#302		11i - (VLL)	201	<i>-</i>	-		
	JUN 201995 Ax	his Devoler R	erdall								
									DHMH-18 Rev 1/8		



tached for use as the burial-transit hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be de	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.	IMPORTANT: If tem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at or
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95 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH YEAR PAUL SCOTT TRAVER JUNE 12 1995 10:20 p 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) B. BIRTHPLACE (State or Foreign Country)

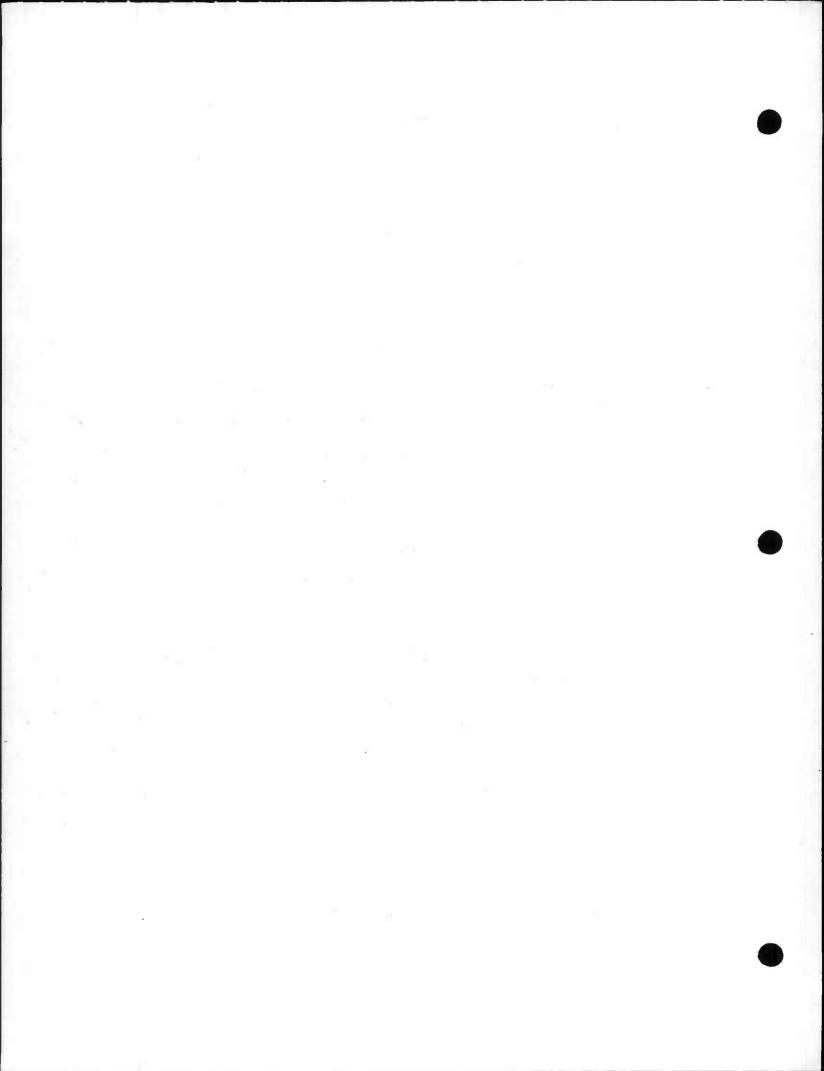
	5//-05-00/	8	T LAN 2 L P	86	YRS.					Nov.	25,	1908	Ma	ryland
	9a. FACILITY NAME (If not ins	titution, give :	street end number)			9b. CITY	, TOWN C	OR LOCAT	ON OF DE			9c. COU		
NC.	Golden Oaks	Nurs	ing Home			Lau	re1					Prin	ce (George's
E	RESIDENCE OF DEC											1		00160
JE.	10e. STATE	10b. COUNT	Υ		10c. CIT	Y, TOWN C	OR LOCAT	TION .						10d. INSIDE CITY
DIRECTOR	Maryland	Landover Hills									LIMITS?			
₹	10e. STREET AND NUMBER						101. ZIP CODE 10g.					10g. CITI	ZEN OF	WHAT COUNTRY?
FUNERAL	6709 Redfi	eld A						2078	<u> </u>			U.S.	Α.	
BY FU	11. MARITAL STATUS 1 Never Married 2 B 3 Widowed 4 Divor		12. WAS DECEDENT FORCES? 1 ! IF YES, GIVE WI WW TT	Y YES 2	ARMED NO		It yes, sp	ecify Cubi	OF HISPAN III, Mexicer Specify	IC ORIGIN? n, Puerlo Ric	(Specify Ye an, etc.)	s or No—	14. RAC Blac Spec	E — American Indian, k, White, atc. Hy: White
0	15. DECE	15. DECEDENT'S EDUCATION					CCUPATIO	NA .		185 8	IND OF BU	SINESS/IND	HOTOV	WILLE
COMPLETED	(Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4 or 5+)				(Give kind of life. Do NOT u	work done (se retired.)	during mo	st of worki	ng	Vet	eran	's Ad	min	istration
Ž.	8		ection	i Chi	Lei						SG	overnment		
	17. FATHER'S NAME (First, Mic									AE (First, Mic				
BE	William S.		er		Mary Ellen Connolly									
2	19e. INFORMANT'S NAME (Ty)				19b. MAILING									
۴	Mary T. Tra				1712	Jacks	son S	Stre	et, E	Baltin	nore,	Mary	1an	d 21230
	20a, METHOD OF DISPOSITION 1 N Burlel 2 □ Cremetion		The state of the s						ATE 20c. LOCATION — City or Town, State					
	4 Donation 5 Other (Mt.	01ive	t Cen	nete:	ry	06/1	15/95	Was	hingt	on.	DC
	21. SIGNATURE OF FUNERAL	SERVICE UN	ENTE			22.	NAME AN	D ADDRE	SS OF FAC	HLITY	-		~~	ne, P.A.
	1- 1- 1 Emu	1.8	French											ne, P.A. MD 20781
	23. PART i. Enter the die	easea, or	complications that	caused the	deeth. Do i	not enter	the mo	de of dy	ing, auch	ea cardie	c or reap	iratory arr	eat,	Approximate
	iMMEDIATE CAUSE (Final disease or condition		Liat only one caus											Onset and Death
- 1	resulting in death)		DUE TO (OR AS A CONS	S A CONSEQUENCE OF):							1 WEEK		
NO	Sequentially list condition		b. History of Cerchrovescolar accident Sevent									Sevent		
CATI	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury													
RTIFI	that initieted eventa resulting in death) LAST		DUE TO (OR AS A CONS	EOUENCE O	F):								
S			d											-
YSICIAN: MEDICAL CERTIFICATION	PART II. Other significant	K151		leeth but no	t resulting	in the un	nderlying	ceuse	given in I		4a. WAS AN PERFO	RMED?	246	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
E I											-			OF DEATH? 1 YES 2 NO
ä	DID TOBACCO US	E CONT	RIBUTE TO CAL	JSE OF DE	ATH YE	S 🗆 1	NO [UNC	ERTAIN					
8	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL		26. PL	ACE OF DEA									
S	1 TYES 2 NO		HOSPITAL: 1 Inpetient 2	ER/Outpatient	3 DOA	OTHER Wun	R: sing Hom	• 5 □ Ra	sidence (6 Other (Specify)			
F	27. MANNER OF DEATH 1 Netural 5 P		28e. DATE OF II (Month, Day	NJURY (, Year)	28b. TIM	E OF URY M	-	URY AT RK? YES 2	NO	28d. DESC	RIBE HOW	NJURY OCC	URED	
TED BY	3 Suicide 8 C	ould not be etermined	28e. PLACE OF building, a	INJURY — At tc. (Specify)	home, term,	street, fact	ory, office			28t. LOCATION (Street end Number or Rural Route Number, City or Town, State)				
COMPLETE			CIAN: To the beat of a											
8	-4/			marion end/c	n investigatio	n, in my o	pinion, de				d place, ar	id due to th	e cause(e) end manner se stated.
BE	256. SIGNATURE AND TITLE	a CENTINE	N)				29c. UC	TU-	BER		29d. DATE	SIGNED	(Month, Day, Year)

ON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Dr. John Margolis, 14333 Laurel Bowie Road, #307, Laurel, Maryland M.D.

32. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year) JUN 1 9 1995

2



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the buspital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

FOR 1 - STATE REGISTRAR	STATE OF MARYLAND / DEPAI CERTIF	RTMENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATN	3. TIME OF DEATH				
	mpsin		MONTH DAY 06 /3 /9	195 640 pm M				
2	6. AGE (In yrs. lest birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	(Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)				
Sa. FACILITY NAME (If not institution, give street	7 07	96. CITY, TOWN OR LOCATION OF DE	4-29-30 sath se. coun	TY OF DEATN				
GOUEN ONES A	JURSING HOME	LAUREL, M	D Pr	WIR GEORGE				
10a. STATE 10b. COUNTY P.G	10c. Cf	TY, TOWN OR LOCATION LAUREL		10d. INSIDE CITY LIMITS? 1 YES 2 NO				
10e. STREET AND NUMBER		101. ZIP CODE	10g. CITIZ	EN OF WHAT COUNTRY?				
11. MARITAL STATUS	2. WAS DECEDENT EVER IN U.S. ARMED	13 WAS DECENDENT OF NISPAN	IIC ORIGIN? (Specify Yea or No	14. RACE — American Indian,				
1 Never Married 2 Married	FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	If yes, specify Ouban, Maxica 1 YES 2 NO Specify	n, Puerto Ricen, etc.)	Black, White, etc.				
3 Wildowed 4 Divorced 15. DECEDENT'S EDUCAT	TON to DECEMBE			BLACK				
(Specify only highest grade co		S USUAL OCCUPATION work done during most of working use retired.)	16b. KIND OF BUSINESS/INDI					
17. FATNER'S NAME (First, Middle, Last)	NUTRITI	ION SPECIALIST	7	ES DEPTOF AGR.				
	ANDER THOMPSON	- 4.	ME (First, Middle, Malden Sumame) OUISE CLARK					
19a. INFORMANT'S NAME (Type/Print)	19b. MAILIN	G ADDRESS (Street and Number or Rural I	Route Number, City or Town, State, Zip	Code)				
ALBERT W. MATTHEW		ROBERT LEWIS AVE.						
1 Department of Disposition 3 Remove	at from State 20b, PLACE AND DATE	other place) PARK	DATE 200. LOCATION - C					
21. SIGNATURE OF FUNERAL SERVICE LICEN	ISER O A	22. NAME AND ADDRESS OF FA		WASH.				
> Stonewall	1- Steward	HOFFMAN FUN, J	ER. 1425 MD. AV	00711				
23. PART i. Entar the diseases, or corehock, or heert failure. Lie	mpilcations that caused the death. Do et only one ceuse on each line.	not enter the moda of dying, suc	ss cerdiac or respiratory arre	Approximate				
IMMEDIATE CAUSE (Finel disease or condition resulting in death) e. Recyclical Vascular Pricare 3445								
resulting in death) e	DUE TO (OR AS A CONSEQUENCE O	PHILLIAN PHI	luce	3 yes				
Sequentieily list conditions,	DUE TO (OR AS A CONSEQUENCE O	NE).						
If sny, leeding to immediate cause. Enter UNDERLYING	DOE TO JOH AS A CONSEQUENCE (or).						
CAUSE (Disease or injury that Initiated evente resulting in deeth) LAST	DUE TO (OR AS A CONSEQUENCE O	DF);						
d.								
PART II. Other eignificent conditions	contributing to deeth but not resulting	In the underlying causa given in	Pert I. 24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
			1 TYES 2 NO	CDMPLETION OF CAUSE OF DEATH?				
DID TOBACCO USE CONTRI	BUTE TO CAUSE OF DEATH Y	ES I NO I LINCEPTAIN		CDMPLETION OF CAUSE				
25. WAS CASE REFERRED TO MEDICAL		ATN (Check only one)		CDMPLETION OF CAUSE OF DEATH?				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	26. PLACE OF DE/ 1OSPITAL: Inputient 2 ER/Outputient 3 DOA	ATN (Check only one) OTHER: 4 Nursing Home 5 - Residence	\	CDMPLETION OF CAUSE OF DEATH?				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 27. MANNER OF DEATH Netural 5 Pending	26. PLACE OF DE/ 1OSPITAL: inpetient 2 ER/Outpetient 3 DOA 26a. DATE OF INJURY 26b. TII	ATN (Check only one) OTHER: 4 Nursing Home 5 - Residence	\	CDMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	26. PLACE OF DE/ 1OSPITAL: inpetient 2 ER/Outpetient 3 DOA 26a. DATE OF INJURY 26b. TH	ATN (Check only one) OTHER: 4 Nursing Home 5 Realdence ME OF 28c. INJURY AT JURY M 1 YES 2 NO	6 Other (Specify)	CDMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined	26. PLACE OF DEJ 26. PLACE OF DEJ 26. DATE OF INJURY (Month, Dey, Year) 26. PLACE OF INJURY — At home, ferm, building, stc. (Specify)	ATN (Check only one) OTHER: 4 Nursing Home 5 Residence ME OF JURY AT WORK? 1 YES 2 NO street, factory, office	6 Other (Specify) 26d. DESCRIBE HOW INJURY OCC 261. LOCATION (Street and Number of City or Town, State)	CDMPLETION OF CAUSE OF DEATH? 1 YES 2 NO URED Or Rural Route Number,				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only 1	26. PLACE OF DEJ 26. PLACE OF DEJ 26. PLACE OF DEJ 26. PLACE OF INJURY	ATN (Check only one) OTHER: 4 Nursing Home 5 Residence ME OF JURY AT WORK? 1 YES 2 NO street, factory, office	6 Other (Specify) 26d. DESCRIBE HOW INJURY OCC 261. LOCATION (Street and Number of City or Town, State)	CDMPLETION OF CAUSE OF DEATH? 1 YES 2 NO URED Or Rural Route Number,				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only 1	26. PLACE OF DEJ 26. DATE OF INJURY (Month, Dey, Year) 26. PLACE OF INJURY — At home, ferm, building, stc. (Specify)	ATN (Check only one) OTHER: 4 Nursing Home 5 Residence ME OF JURY AT WORK? 1 YES 2 NO street, factory, office	6 Other (Specify) 26d. DESCRIBE HOW INJURY OCC 261. LOCATION (Street and Number of City or Town, State) to the cause(s) and menner as state time, data and place, and due to the	CDMPLETION OF CAUSE OF DEATH? 1 YES 2 NO URED Or Rural Route Number, d. ceuse(s) and manner se steted.				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER	26. PLACE OF DEJ 26. DATE OF INJURY (Month, Dey, Year) 26. PLACE OF INJURY — At home, ferm, building, stc. (Specify)	ATN (Check only one) OTHER: 4 Nursing Home 5 Residence ME OF 28c. INJURY AT WORK? I YES 2 NO atreet, factory, office red at the time, data and place, end due on, in my opinion, death occured at the	6 Other (Specify) 26d. DESCRIBE HOW INJURY OCC 261. LOCATION (Street and Number of City or Town, State) to the cause(a) and menner as state time, data and place, and due to the IBER 29d. DATE	CDMPLETION OF CAUSE OF DEATH? 1 YES 2 NO URED Or Rural Route Number,				
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25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER MODILIAN SIGNATURE 30. NAME AND ADDRESS OF PERSON WHO CO	26. PLACE OF DEJ 26. DATE OF INJURY (Month, Dey, Year) 26. PLACE OF INJURY — At home, ferm, building, stc. (Specify) AN: To the best of my knowledge, dasth occur On the basts of exemination and/or investigati	ATN (Check only one) OTHER: 4 Nursing Home 5 Residence ME OF JURY M 1 YES 2 NO street, factory, office red at the time, data and place, end dua on, in my opinion, death occured at the 29c. LICENSE NUM 0 3 6 7	6 Other (Specify) 26d. DESCRIBE HOW INJURY OCC 261. LOCATION (Street and Number of City or Town, State) to the cause(a) and menner as atlate time, data and place, and due to the IBER 29d. DATE	CDMPLETION OF CAUSE OF DEATH? 1 YES 2 NO URED Or Rural Route Number, d. ceuse(s) and manner se steted. SIGNED (Month, Day, Year)				

	1	FOR STATE REGISTRAR	STATE OF N	MARYL	AND / DEP					MENT	AL HYGIEN				
		1. DECEDENT'S NAME (First, Middle, Last)	THER	WAr						MON	E OF DEATH	477 1	995	TIME OF DEATH	_
	- 1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (I	n yrs. lest birthde	y) IF UND	ER 1 YEAR	IF UNDER	A 24 HRS.	7. DAT	E OF BIRTH	771	8. BIRTHPI	LACE (State or Foreign	_
	t	214-70-2557	1 📉 M 2 🗌 F	3	38 YRS	MONTHS	DAYS	HOURS	MIN.		il 29, 1	957	Mary		
sponid		9e. FACILITY NAME (If not inetitution, give e	treet and number)			96. CIT	Y, TOWN	OR LOCATI	ION OF O				NTY OF DEA		_
2, 3	5	Howard County Ger	neral Hos	spita	1	Co1	umb i	La				How	ard		
= 8	5	RESIDENCE OF DECEDENT					7.0.002							_	
=	DIMECTOR	Maryland Howa				10c. CITY, TOWN OR LOCATION Columbia							Od. INSIDE CITY LIMITS? YES 2 NO		
	EHAL	9635 Whiteacre Road #A3					10	2104				U.S		AT COUNTRY?	
	0	11. MARITAL STATUS 1 Never Married 2 Married 3 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES	2 X NO	If yea, specify Cuban, Mexicen, Puerto Rican, etc.)					14. RACE - Black, 1 Specify:	- American Indian, White, atc. White			
The as	ו ה	15. DECEDENT'S EQUA								16	Sb. KIND OF BU	SINESS/IND	DUSTRY		_
		College (1-4 or 5 +)				use retired.	during m	ost of workin	ng		Constru	ctio	n		
Once.	֝֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	17. FATNER'S NAME (First, Middle, Last)	Painter												_
, la		Albert James Therwanger						18. MOTNER'S NAME (First, Middle, Melden Surneme) Dorothy Marlatt							
notified TO RE		19+, INFORMANT'S NAME (Type/Print)	NG ADDRES	S (Street				mber, City or Tow	n, State, Zic	Code)		-			
	-	Lori Therwanger												and 21045	
De de		20s. METHOD OF DISPOSITION 1 N Burial 2 Cremation 3 Remo	E OF OISPO	SITION /A/	eme of		- 04	TE 200 LO	CATION	City on Town	Panta	-			
must.	L	Donation 5 Other (Specify)	over from State	MD	Natio	al M	emor	ial I	Park	6/17	7/95 Lau	irel.	Marv	1and	
examiner must be	I	21. SIGNATURE OF FUNERAL SERVICE LIC	F F	name a	is G	ss of fa asch	S	Sons Fu	neral	1 Home	e, P.A.	_			
	+	23. PART I. Enter the diseases, or o	ALL V	Coursed	the death D	4	739	Balt	imor	e Av	7e., Hy	atts	ville	MD 20781	_
		snock, or neart lailure.	ch line.	not ente	r the mo	pae or ayı	ing, suc	n as ca	rdiac or resp	iratory an	rest,	Approximate interval Between	1		
5 E		IMMEDIATE CAUSE (Final disease or condition	Ca			1 In Lastin								Onset and Deati	n
ial, cremation,	Н	resulting in desth)	CONSEQUENCE	sel Infaretion								1 week	5		
- E				Hailung					75 4001						
or other traumatic	5	Sequentially list conditions, if any, leading to immediate	CONSEQUENCE						/5 pur	2					
TAT	١	cause. Enter UNDERLYING	Hy		beari							715 Year	Α.		
other		CAUSE (Disease or Injury that initiated events	DUE TO											100	ב
njury, or other traumatic		resulting in desth) LAST	. Insulie dependent rélats. Mellitus 32 re							32 Year	2				
injury, o		PART ii. Other aignificant conditions	a contributing to	death bu	it not resultin	g in the u	nderlyin	g cause (given in	Part i.	24a. WAS AN PERFOR	AUTOPSY		ERE AUTOPSY FINDINGS	
3 shows any i	3										1 TYES 2		0	OMPLETION OF CAUSE F DEATH?	1
shows														TES 2 NO	
		DID TOBACCO USE CONTR	RIBUTE TO CA	USE OF	DEATH	res 🗆	NO D	UNC	ERTAIN	V 🗆				-	
SICIAN:		25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	2	6. PLACE OF D										
d, or item 23 s		1 NES 2 NO	Inpatient 2	ER/Outpa	tient 3 🗆 DOA	4 Nu		10 5 🗆 Re	sidence	8 🗆 Oth	er (Specify)				
ked, or PHY		27. MANNER OF DEATH	28e. DATE OF (Month, Da	INJURY Y YOU')		IME OF	28c. INJ	JURY AT		28d. DE	SCRIBE NOW I	NJURY OC	CURED		7
		1 Natural 5 Pending 2 Accident Investigation				M	1 🗆		NO						
28 is		3 Suicide 6 Could not be determined	28e. PLACE Of building, o	INJURY - Inc. (Specif	At home, fern	, street, fac	tory, olfic	•			CATION (Street of or Town, State)		or Rural Rou	te Number,	
IMPORTANT: If Item 28 I		290. CERTIFIER CERTIFYING PHYSIC	CIAN: To the best of	my knowle	dge, death non	rred et the	time data	and place	and due	to the co	nunatal cod o	andri se			4
= 5		2 MEDICAL EXAMINE	R: On the basie of ex											nd manner ee stated.	
MPORTANT:		29 SIGHATURE AND TITLE OF CERTIFIER						29c. LICE	NSE NUN					onth, Day, Year)	
₹ 0		30. NAME AND ADDRESS OF PERSON WHO						V	30	404	}	6.	une	1415 1995	

AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 2D (Type, Print) # 100.

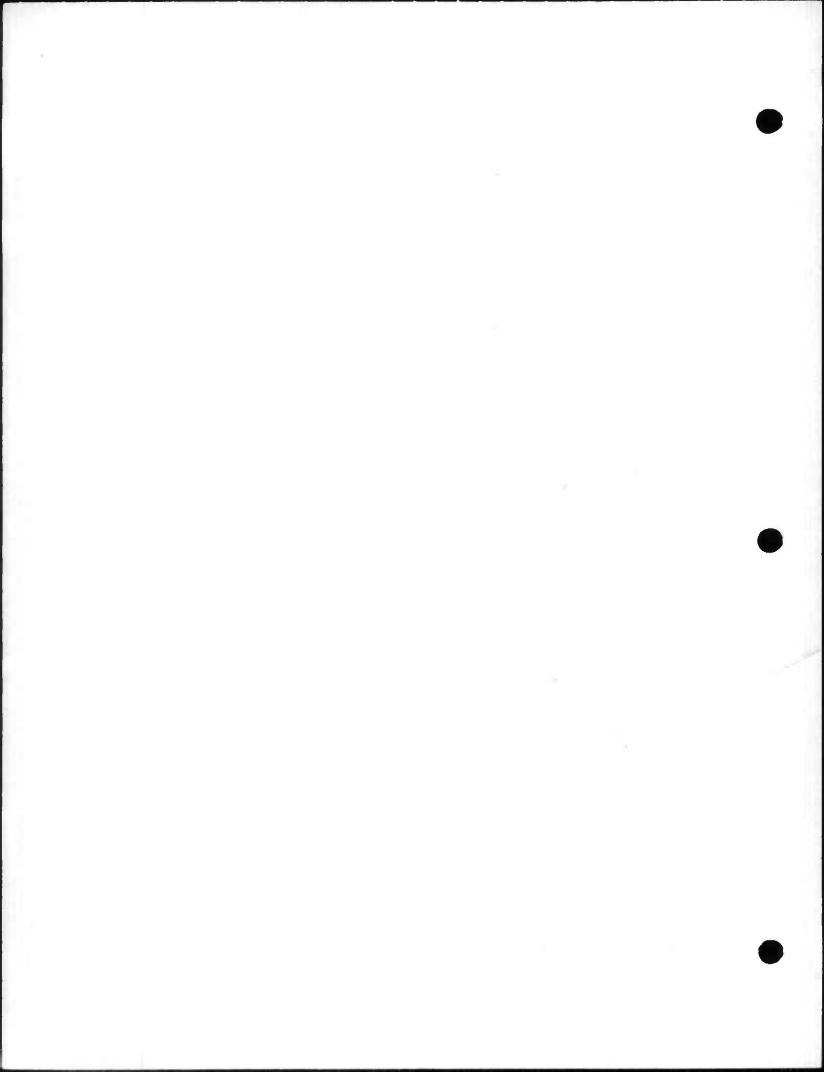
32. REGISTRAR'S SIGNATURE

VELLANKI

MD. 21042

Ellicott

Cioy



DIVISION OF VITAL RECORDS, P.O. BOX 68760

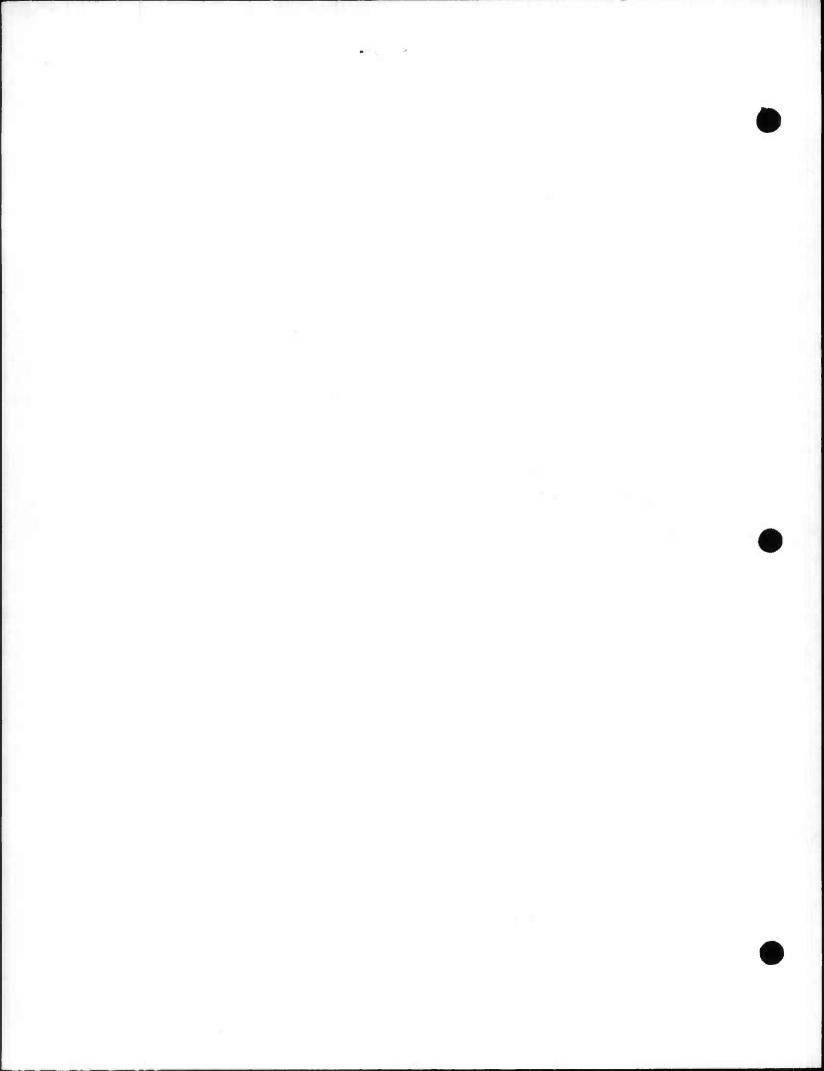
1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.

1. DECEDENT'S NAME (First, Middle, Last)

Pohont

Stevens

	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF DEATN			3. TIME OF DEATH	
	Robert		Stevens			Tarnay				June 27, 1995		PAR	2.25 P M	
	4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER	1 YEAR	IF UNDER		7. DATE OF BIRTH	1995	0. BIRTNP	LACE (State or Foreign	
İ	223-60-7577		1 📉 M 2 🗆 F	82	YRS.	MONTHS	DAYS	HOURS	MIN.	May 13	913	New	York, NY	
_	9a. FACILITY NAME (If not in	nstitution, give s	treet and number)			9b. CITY	TOWN	OR LOCATE	ON OF D	EATH	9c. COU	NTY OF DE	ATN	
5	Physicians	Memori	al Hospi	tal		La	P1at	ta			Char	1es		
	10a. STATE	10b. COUNT			10c. CIT	Y, TOWN C	R LOCA	TION					10d. INSIDE CITY	
DIRECTOR	Maryland	Char	les			wbur							LIMITS?	
	10. STREET AND NUMBER							f. ZIP COD	E		10g. CIT		AT COUNTRY?	
FUNERAL	14078 River	Road							206	64		USA		
15	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. AR	MED	13.	MAS DEC	ENDENT C	F HISPAI	NIC ORIGIN? (Specify Y	a or No-	14. RACE -	- American Indian, White, etc.	
BY	1 Never Merried 2 X			WAR OR DATES			Yes, sp	2 NO	Specif	in, Puerto Rican, atc.) y:		Specify:		
		EDENT'S EDU	CATION	to DE	CEDENTIA	USUAL O							White	
		ly highest grade		(G	ive kind of a	work done o	luring mo	ost of working	9	16b. KIND OF BU	JSINESS/INT	USTAY		
1 4	Listing processing (,	5+		ttorr	ney				Private	Prac	ctice		
COMPLETED	17. FATNER'S NAME (First, M									ME (First, Middle, Malde				
BE		Victor W. Tarnay Irma Einhold Tarnay												
5	19a. INFORMANT'S NAME (Type/Print) Robert S. Tarnay 19b. MAILING ADDRESS (Street and Number or Farall Route Number, City or Town, State, Zip Code) 14078 River Road Newburg, MD 20664													
	20e. METNOD OF DISPOSITION 1 Burlei 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) DATE 20c. LOCATION - City or Town, State Date Cremetory of a the property of the propert										n, State VA			
	21. SHICHAY GIE OF JUNERAL SERVICE LICENSEE MO0173 M													
	My K	1 /	V		13	44	33	White	P]	Mortuary s La White	Pls.	, MD	20695	
	23. Port I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying such as cerdiac or reeniratory errect.													
	IMMEDIATE CAUSE (Fir	ehock, or heart feliure. List only one cause on each line. interval Between Onset and Death												
4	disease or condition resulting in death) a. Sepsis Due to (or as a consequence of):													
200														
ON	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or latery) C. ASPIRATION													
X														
E E	Cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events C. ASPICATION DUE TO (OR AS A CONSEQUENCE OF):					-								
CERTIFICATION	resulting in death) LAS	T L	d. Syp	ra-bulbar palsy										
	PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PINDINGS													
EDICAL	upper Gastrointes tras hemorrans & PERFORMEDT									_ A	WAILABLE PRIOR TO			
							V	,		¹ U YES	1 - YES 2 NO		OF DEATH? 1 YES 2 NO	
2	DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF DEA	TH YE	S 🗆 1	10 E	UNC	ERTAI	<u></u>		- '	TES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)													
YSI	The spital: The spital Important Im													
5	27. MANNER OF DEATN 1 Netural 5	Pendina	28a. DATE OF (Month, D		26b. TIM INJ	E OF URY		RK?		28d. DEŞCRIBE NOW	INJURY OC	CURED		
	2 Accident Investigation							M 1 YES 2 NO				1000TON O		
	3 Suicide 6 Could not be detarmined 26s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 26s. PLACE OF INJURY — At home, farm, street, factory, office City or fown, State) 26s. LOCATION (Street and Number or Rural Route Number or								ute Number,					
E	29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
COMPLETED	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and manner as stated.													
BE	29b. SIGNATURE AND TITLE OF CERTIFIER			1	29c. LICENSE NUM				IBER 29d. DATE SIGNED (Month, L			Month, Day, Year)		
P	30, NAME AND ADDRESS OF	PERSON WA	OCCUMPLETED CALL	SE OF DEATH #===	1 970 (%	Direct Control		D-33			- (1+7	175	
	B. Larry Je	B. Larry Jenkins, M.D. 1724 La Plata, Maryland 20646						4						
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE JUN 2 9 1995 Julia Daudean Raylall													
	JUNES	1333	yava ava	DATA LINE AND AND AND AND AND AND AND AND AND AND	all									



nours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

		FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART CERTIFIC			MENTAL HYGIEN		20100
	ᇣᅵᇤᅵ			SRNEY .	JR		2. DATE OF DEATH	الا الآ	3. TIME OF DEATH
핃		218-20-6776	1 Ø M 2 □ F		IF UNDER 1 YEAR IONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Aug. 26 19	117	BIRTHPLACE (State or Foreign Country)
2, 3 shot		P. SACILITY NAME (If not institution, give s D. BH 92 RESIDENCE OF DECEDENT	treet and number)			CR LOCATION OF DE	ATH J		Y OF DEATH AERSE T
t. Pages 1		10e. STATE 10b. COUNT	ONERSET		TOWN OR LOCAT				10d. INSIDE CITY LIMITS? 1 YES 2 NO
physician. burial-transit permit. Pages 1, 2, 3 should		P.O. BH 92				ZIP CODE	7	10g. CITIZE	N OF WHAT COUNTRY?
ling physiciar the burial-tra		11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 740	If yee, sp		IC ORIGIN? (Specify Yen, Puerto Rican, atc.)	e or No— 14	I. RACE — American Indian, Black, White, etc. Specify: Black
be retained by the hospital or attending physician. ge 5 should be detached for use as the burial-tran e notified at once.		15. DECEDENT'S EOU (Specify only highest grade Elementery/Secondary (0-12)		18e. DECEDENT'S US (Give kind of wor life. Do NOT use	rk done during mo	st of working	SEAF		
by the hos i be detach		17. FATHER'S NAME (First, Middle, Last)	ney SR				ME (First, Middle, Maiden		
y be retained I age 5 should be notified	TO B	190. INFORMANT'S NAME (Type/Print) JOSEPH S. TOLL	ney II	19b. MAILING A	West	ast office	Oute Number, City or Tow	vn, State, Zip Co	mar, MD 21853
ge 6 may be lirector, page r must be		20e. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Rem 4 Donelion 5 Other (Specify)	oval from State	PLACE AND DATE OF etery, cremetally or ethe	er place)	· Cemetal	6/24/45 C	" : CD.	y or Town, State
hours after death. Page 6 may din by the funeral director, pa or removal. medical examiner must b		21. SIGNATURE OF FUNERAL SERVICE LIC	D. Ward		ANTI	hong E. William St. C	aid tunera	MD. o	
with pletely fille cremation, rent, the	AL CERTIFICATION	23. PART i. Enter the diseases, or shock, or heert fellure. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth)	complications that caused List only one cause on e	the death. Do not ech line.	reclass	de of dying, such	ae cerdlec or reep	Iretory erres	t, Approximate interval Between Onset and Deeth
the death certificate be executed the attending physician and corrid Mental Hygiene prior to burial, injury, or other traumatic ev		Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST	•	COMSEQUENCE OF):		/			7000
at the death by the atter and Mental		PART II. Other significent condition	s contributing to deeth b	ut not resulting in	the underlying	g ceuse given in	Pert I. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that TO THE FUNERAL OIRECTOR: After this certificate has been signed by be filed within 72 hours after death with the State Oept. of Health an IMPORTANT: If Item 28 is marked, or Item 23 shows any							1 🗆 YES :	3	COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
t: The law cate has be state Oept.		DID TOBACCO USE CONTI	HOSPITAL:	26. PLACE OF DEATH	(Check only one)				
PHYSICIAN this certifi with the S		27. MANNER OF DEATH **EXAMPLICATION 5 Pending	1 Inpatient 2 ER/Oulp 28e. DATE OF INJURY (Month, Day, Year)	28b. TIME (RY WO	URY AT RK?	8 Other (Specify) 28d, DESCRIBE HOW I	NJURY OCCUP	RED
ATTENOING CTOR: After after death 28 is ma		2 Accident 3 Suicide S Could not be determined	28e. PLACE OF INJURY — At home, Jerm, strael, Jectory, office building, etc. (Specify)			28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
PITAL OR A ERAL OIRE in 72 hours T: If Item			CIAN: To the best of my knowl						euse(e) end menner ee stated.
O THE HOS O THE FUN is filed with	B	296. SIGNATURE AND TITLE OF CERTIFIER		les .	an	29c. LICENSE NUM D1021	BER	29d. DATE S	IGNED (Month, Day, Year) 23-95
	10	James A. Sterl:	ing, M.D. F	Box		isfield		21817	55-55
		31. DATE FILED (Month, Day, Year)	32. REGISTRAB'S BIGNI	NORE					

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DIVISION OF VITAL I	
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

(NA)

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the model. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

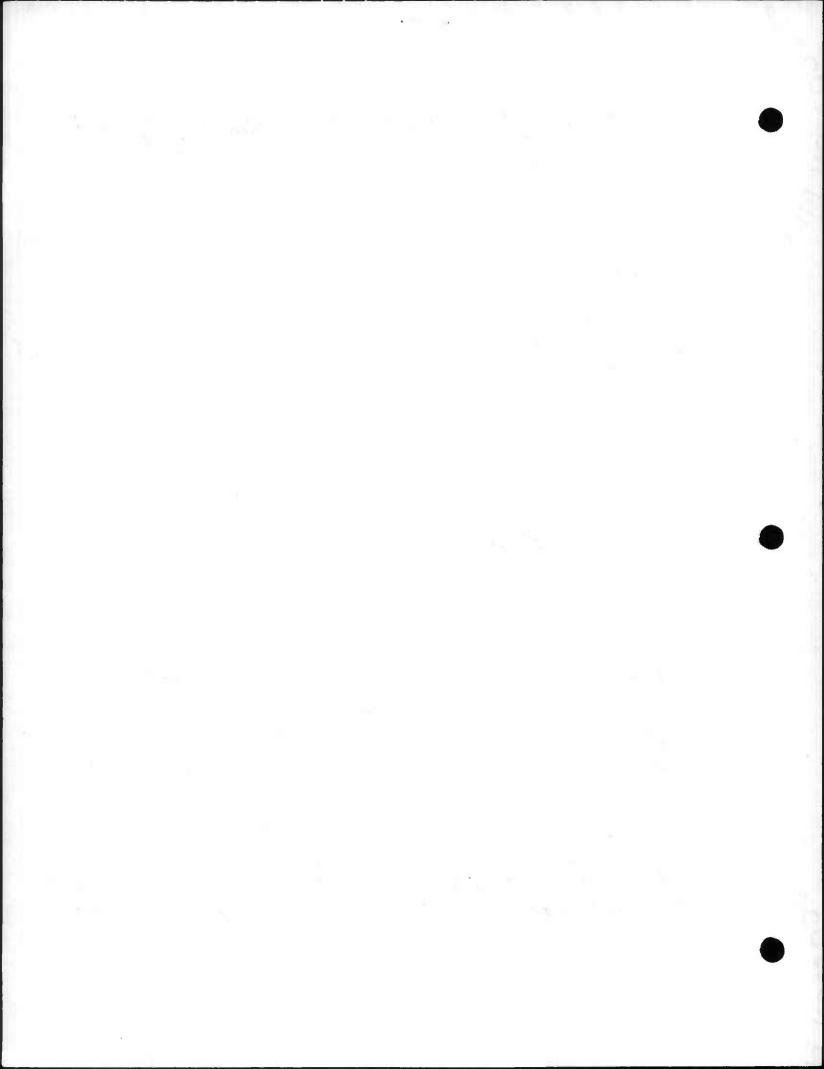
TO BE COMPLETED BY FUNERAL DIRECTOR

1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI			MENTAL HYGIENE REG. NO.				
1. DECEDENT'S NAME (First, Middle, Last)		D E / () ()	2. DATE OF OEATH		3. TIME OF DEATH				
LEO WALT	OLLMER			June 14, 199	95	9:15 A M			
	. SEX 8. AGE		F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		HPLACE (State or Foreign		
216-16-7782	M 2 □ F	7] YAS.	ONTHS DAYS	HOURS MIN.	November 25,	1923 M	aryland		
9a. FACILITY NAME (If not institution, give stree	t and number)	9	b. CITY, TOWN	OR LOCATION OF O	EATH 9	c. COUNTY OF	DEATH		
28620 Ocean Gatew	ay ·		Sali	sbury		Wic	omico		
RESIDENCE OF DECEDENT 100. STATE 100. QUINTY		10c, CITY, 1	TOWN OR LOCA	TION			10d. INSIDE CITY		
Maryland Wic	omico		lisbur			LIMITS?			
10e. STREET AND NUMBER				. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?		
28620 Ocean Gatew	ay		1.	21801		USA			
	2. WAS DECEDENT EVER I				NIC ORIGIN? (Specify Yea or		E - American Indian,		
1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 X YES			ecify Cuben, Mexice 2 XNO Specifi	n, Puerto Rican, atc.)	Spe	ck, White, etc.		
	WW	11					ite		
15. DECEDENT'S EDUCAT (Specify only highest grade cor	mpleted)	(Give kind of work life, Do NOT use n	k done during mo		16b. KIND OF BUSIN	ESS/INDUSTRY			
Elementary/Secondary (0-12)	College (1-4 or 5+)	Used Ca			Automob				
17. FATHER'S NAME (First, Middle, Last)		used ca	i bear		ME (First, Middle, Maiden Sur				
Louis F.	Vollmer			Hazel	ME (First, Middle, Maiden Sur H i				
19e. INFORMANT'S NAME (Type/Print)		19b. MAILING AL	ODRESS (Street o		Route Number, City or Town, S				
Millicent Vollmer					, Salisbury,		801		
200. METHOD OF DISPOSITION	206	. PLACE AND DATE OF				TION — City or T			
1 1 Buriel 2 Cremetion 3 Remova 4 Donetion 5 Other (Specify)		relery, crematory or other pringhill Me	mory Gar	dens	1	ebron,			
21. SIGNATURE OF FUNERAL SERVICE UCEN			22. NAME A	ND ADDRESS OF FA	CILITY	LOTOII,			
►////C//	Ilen	~~-			neral Home	,	ND 01001		
23. PART i. Entar tha diseases, or con	nplications that cause	the death. Do not	antar tha mo	da of dving, auc	ll Rd., Sali	lory arrest	Approximata		
ahock, or haart fallure. Lis	t only one cause on a	ach lina.		, , , , , , , , , , , , , , , , , , , ,		, =110011,	Intarval Between Onset and Death		
iMMEDIATE CAUSE (Final disease or condition	Made	mt lu	200				Onset and Daath		
resulting in death) a	OUE TO (OR AS A	CONSEQUENCE OF)	11000	YNEL			SWW		
			·				1		
Sequantially list conditions, if any, laading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):							
CAUSE (Disease or injury									
that initiated eventa resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):							
d									
PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a, WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS									
					PERFORME		AWAILABLE PRIOR TO COMPLETION OF CAUSE		
						(OF DEATH?		
DID TOBACCO USE CONTRIB	BUTE TO CAUSE O	F DEATH YES	□ NO	UNCERTAIN	<u> </u>				
25. WAS CASE REFERRED TO MEDICAL	IOSPITAL:	28. PLACE OF OEATH	(Check only one)	1					
1 UYES 2 NO 1	☐ Inpatient 2 ☐ ER/Outp	atient 3 DOA 4	THER: Nursing Hom	e 5 Residence	8 Other (Specify)				
27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME C		URY AT	28d. OEŞCRIBE HOW INJU	JRY OCCUREO			
1 Netural 5 Pending 2 Accident Investigation			M 1 🗆	rES 2 NO					
3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Spec	— At home, ferm, atre	et, 1ectory, offic		281. LOCATION (Street and City or Town, State)	Number or Rural	Route Number,		
4 Pomicide determined									
29e. CERTIFIER (Check only per land) (Check									
one) 2 MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and menner as stated.									
29b. SIGNATURE AND SUILE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year)									
10 20507 6 (15/9s									
10 HAME AND ADDIESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) - Grasso, 145 E. Carroll St., Salisbury, Md. 21801									
31. DATE FILEDIMONTIL Day, Year) 32. REGISTRAR'S SIGNATURE									
JUN 16 1995 Julia Studior Revolt									

and were the residence

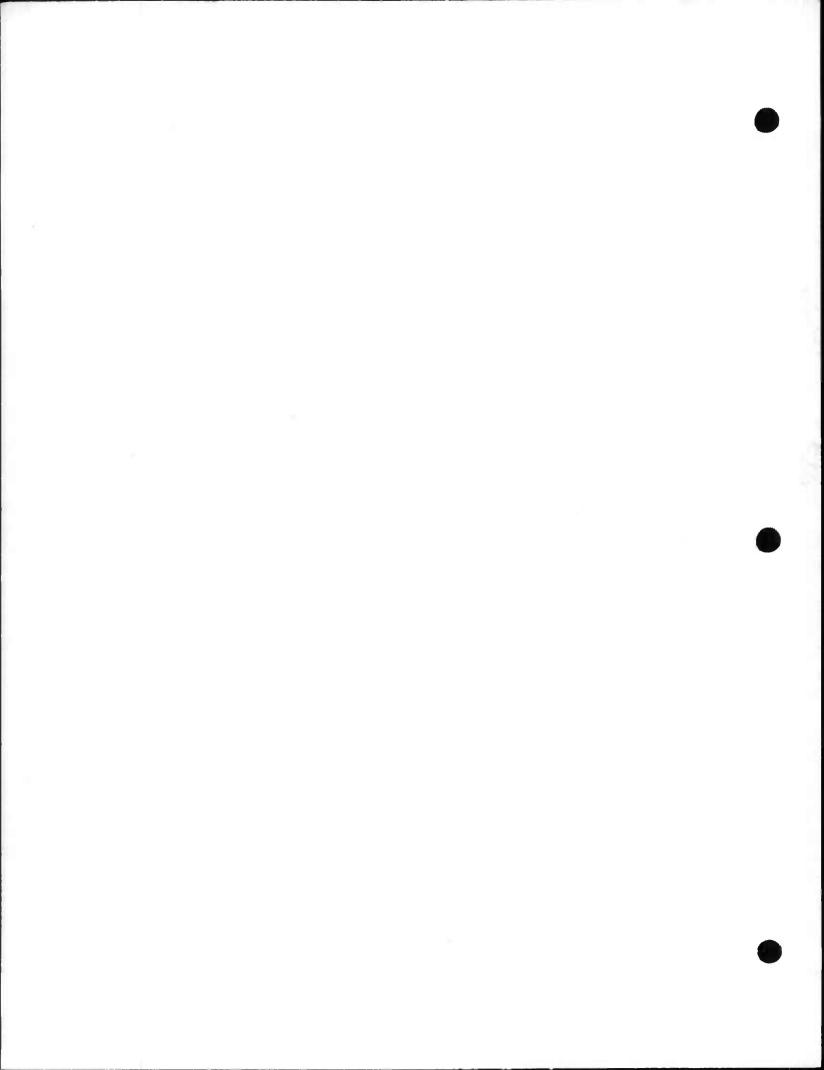
TO THE HISPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate he executed within 24 hours after death. Page 6, may be executed by the hospital or stranding shearing	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 72 hours are the burial-transit permit. Pages 1, 2, 3 should within 72 hours are the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.	FTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after	TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the before within 72 hours after death with the State Deor, of Health and Merital Hydere prior to burial, cremation, or emona	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical

	FOR 1 STATE		STATE OF M	MARYLAND	/ DEPAR	RTMENT	OF H	EALTH	AND I	MENTAL HYGIEN	ie .	0	
	REGISTRAR			(CERTIF	ICATE	OF	DEAT	Ή	REG. NO).		
		enn	0		Whit	che	col			2. DATE OF DEATH MONTH WALL 27	119	95°	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMB 215 - 20 - 2	2826	5. SEX 1 X M 2 F	6. AGE (In yrs. 69	lest birthday) YRS.	IF UNDER 1	YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF BIRTH (Morth, Day, Year) June 5,	1926	Count	HPLACE (State or Foreign try) yland
OR	99. FACILITY NAME (N not ins					вь. спту, Laur		R LOCATIO	ON OF DE	ATH		NTY OF D	George
رخ	RESIDENCE OF DEC	10b. COUNTY	,			Y, TOWN OF							
DIR	Maryland		e George			rel							10d. INSIDE CITY LIMITS? 1 X YES 2 NO
VERA	911 Park Avenue #208							21P CODE			USA		WHAT COUNTRY?
BY FUNERAL DIRECTOR	11. MARITAL STATUS 1 X Never Merried 2 3 Diver		IF YES, GIVE W	X YES 2		- 11	yes, spe	ENDENT O	s, Mexicar	IC ORIGIN? (Specify Yen, Puerlo Rican, etc.)	s or No—	Spec	E — American Indian, ik, White, etc. ://y: White
ED	15. DECE (Specify only	EDENT'S EDUC	CATION COmpleted	16e.	DECEDENT'S (Give kind of	USUAL OC	CUPATIO	N		16b. KIND OF BU	SINESS/INC		MILCE
COMPLETED	Elementary/Secondary (0- Grade 7		College (1-4 or 5 e)	istodi	se retired.)	ining mos	st or working	9	City Se	ervic	es	
BE CON	17. FATHER'S NAME (First, Mile Lester White	. ,								AE (First, Middle, Meider Snitzer	Surneme)		
	19e. INFORMANT'S NAME (Ty	rpe/Print)			19b. MAJLING	ADDRESS	Street at			oute Number, City or Tox	rn, State, Zip	Code)	
10	Kristi Mills	S			8103	Sandy	Sp	ring	Roa	d, Laurel	, Mar	ylan	nd 20707
	20a. METHOD OF DISPOSITION 1 X Burlel 2 □ Cremation 4 □ Donation 5 □ Other	n 3 🗆 Remo	oval from State	20b. PLAC	EAND DATE	or disposit Cemet	ion (Nai	me of		6/28 La	urel,		
	21. SIGNATURE OF TUNERAL	SERVICE LIC	ENSEE	11				D ADDRES		CILITY			
	1 Klaly	H Ja	y the	in						eral Home ve. Laure	-		
	23. PART I. Entar the dis	seases, of c	omplications that	caused the	daath. Do	not anter t	he mod	da of dyli	ng, such	as cerdiac or resp	Iratory an	rest,	Approximate
	IMMEDIATE CAUSE (Find disease or condition resulting in death)		Ethylis	se on each II	ne.								Interval Between Onset and Death
	,		DUE TO	OR AS A CONS	EQUENCE O	F):							
MION	Sequentially list conditions of the sequential sequenti	late	DUE TO	(OR AS A CONS	EQUENCE O	F):							
CERTIFICATION	cause. Enter UNDERLYIF CAUSE (Disease or Injur that initiated events resulting in death) LAST	y \ '	DUE TO	(OR AS A CONS	EQUENCE O	F):							
H	resulting in death) LAST		d,		<u> </u>								
PHYSICIAN: MEDICAL	PART II. Other algnificer	ku su	s contributing to	daath but not	t resulting	in the und	arlying	cause g	lven in i	Part I. 24a. WAS AN PERFO	RMED?	24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME													1 YES 2 NO
Ä	DID TOBACCO US		RIBUTE TO CA	USE OF DE	ATH YE	S EM	0 🗆	UNC	ERTAIN				
2	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:		ACE OF DEA	OTHER:			/				
1YS	1 YES 2 NO		1 Inpatient 2 I		_	4 🗆 Nursir	ng Home	_	idence (Other (Specify)			
ВУ Р	1 Natural 5 F	Pending nvestigation	(Month, De	ny, Year)		M		RK? ES 2	NO	28d. DESCRIBE HOW	NJURY OC	CURED	
		Could not be letermined	28e. PLACE Of building,	F INJURY — A1 I etc. (Specify)	home, 1erm, :	street, factor	y, office			28f. LOCATION (Street City or Town, State)	end Number	or Rurel F	Route Number,
COMPLET										to the cause(s) end ma			e) end manner ee stated,
BE CC	296. SIGNATURE AND TITLE			21111					NSE NUM				(Month, Day, Year)
5	30. MAME WHO ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF DEATH (IT	EM 27) (Type,	Print	1	121	111	7 5 0	1.1	2	7/1995
	31. DATE FILED (Month, Day, Y	-	42. REGISTRA	R'S SIGNATURE	5009	Kay	av	SHC	1.6	o gn/1	nd	20	748
	JUN 2 8	1995	Julia da	ulear han	dally					•			



1 - FOR STATE REGISTRAR

	_		HEGISTHAN		CE	HILL	CATE	IL DEVI	Н	REG. NO).		
	i	i	1. DECEDENT'S NAME (First, Middle, Last)	M INTE	T A 37					2. DATE OF DEATH	WK OO =	YEAR	3. TIME OF DEATN
			CAROLINE	M. WHE						June 24,	1995		9:00 P.M
			4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las		MONTHS DAY	-	MIN.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHP Country	PLACE (State or Foreign
pla	- 1		217-20-2801	1 M 2 X X F	75	YRS.				May 27,	1920	Ma	ryland
3 should			Sa. FACILITY NAME (If not institution, give					VN OR LOCATIO	N OF DEA	TN		YTY OF DE	
2, 3		DIRECTOR	Frederick Memor	ial Hosp	ital		Free	derick			Fre	ederi	.ck
es 1,		E E	10a. STATE 10b. COUNT	Y		10c. CITY	, TOWN OR LO	CATION					10d. INSIDE CITY
Pa		# I	Maryland Fre	derick			hurmon						LIMITS?
ermit	- 1		10e. STREET AND NUMBER				1	10f. ZIP CODE			I son CITI		1 YES 2 NO
sit p			27 Blue Ridge A	venue				217	88				
020 physician. burial-transit permit. Pages 1, 2,		FUNERAL	11. MARITAL STATUS		YT EVER IN U.S., AR	MED	13. WAS	DECENDENT OF	HISDANIC	ORIGIN? (Specify Ye			States - American Indian,
020 phys		- 11	1 Never Married 2 Married	FORCES?	I YES 24 N	10	If yes	, specify Cuban, YES 2 NO	, Maxican,	Puerlo Rican, etc.)	0,100	Black,	White, atc.
5-0020 nding physic is the burial		B	3 Widowed 4 Divorced					iza z Aj no	арвину.			Specify	White
r attenduse as			15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a, DE	CEDENT'S	USUAL OCCUP	ATION		16b. KIND OF BU	ISINESS/IND	USTRY	
21 21 10 u		9	Elementary/Secondary (0-12)	College (1-4 or 5	+)		,	most of working					
AND 2.	63	COMPLET		4		Teach	ier			Educa	ation		
YLAND 21215-0020 by the hospital or attending physician. be detached for use as the burial-tran	once.	8	17. FATHER'S NAME (First, Middle, Last)					18. MOTHE		E (First, Middle, Maiden	,		
A P	9	W .	William McPhers	on McGil	1				Ca	roline H	Reisle	er	
MARYLAND retained by the hospit 5 should be detached		2	19a. INFORMANT'S NAME (Type/Print)							ute Number, City or Tox			
ay be re	ре по	_	Frederick G. Wh	elan, II	I	6458	Monit	or Stre	et P	ittsburgh	ı, Per	nnsyl	van i a 1521
	must b		20a. METNOD OF DISPOSITION 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Ran	noval from State			F DISPOSITION				CATION -		
MO ge 6		ı,	4 Donation 5 Other (Specify)		Hager	stown	i Crema						Maryland
BALTIMOF after death. Page 6 m by the funeral director,	examiner	!	21. SIGNATURE OF FUNERAL SERVICE LI	DENSITE	0		22. NAMI	E AND ADDRESS	S OF FACI	"Stauffer	Fune	eral	Homes, P.A.
AL deat			1621 Opossumtown Pike Frederick, MD 21702										
	medical		23, PART I. Enter the diseases, or	complications the	at caused the de	ith. Do n	ot enter the	mode of dyin	g, auch	ea cardiac or reap	iratory arr	eat,	Approximate
3OX 68760 ate be executed within 5 hours ysician and completely filled in the	Ē		shook, or heart failure. IMMEDIATE CAUSE (Final	List only one cat	use on each line.	•							interval Between Onset and Death
the state of the s	#		disease or condition	有. C	OR AS A CONSEC	he	my or	Mace					to a set and beating
with	event,		resulting in death)	DUE TO	(OR AS A CONSEC	UENCE OF):	7					Weer)
C 68760 executed with and comple or burial cree	9	z		9-50	harral	L	Mai	26					Martha
X 6	traumatic	CERIIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	OR AS A CONSEC	UENCE OF):	0					1 (000)
BOX	ţ	3	cause. Enter UNDERLYING CAUSE (Disease or Injury	· Cir	rhosE	5							Mouth,
O. E. ertifica	other	<u> </u>	that initiated events	DUE TO	(OR AS A CONSEC	UENCE OF):						
S, P.O. BC death certificate s attending physic	5		reaulting in death) LAST	d									
RDS, P.O. BOX at the death certificate be by the attending physician and Mental Honiene prior to	3	. 19	PART II. Other aignificant condition	as contributing to	death but not re	andida a	Alba conducti		ora In D			1	
CORDS, res that the de igned by the affect and Ment	amy in	EUICAL	Siles agrillouric obligation	- continuating to	Geath Dut 110t H	saulting it	i the underly	ying cause giv	ven in Pa	PERFO	RMED?	97	WERE AUTOPSY FINDINGS WAILABLE PRIOR TO
Signed by t	W 34									1 YES :	2 0		OF DEATH?
T	shov	Σ	DID TODA CCO LICE COAT	DIDLITE TO CA	UCE OF DEAL					_		1	YES 2 NO
VSICIAN: The law requires certificate has been shift the State Dent. of H	Item 23	SICIAN	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	KIBUTE TO CA					RTAIN	96			
VITAL AN: The law tificate has	E C	2	EXAMINER?	HOSPITAL:			OTHER:						
F V SICIAN Certific	0	2	1 YES 2 NO		ER/Outpatient 3					Other (Specify)			
VISION OF VITAL RE ATTENDING PHYSICIAN: The law requestropy. After this certificate has been safer death with the State Dent. of	marked, or		1 Natural 5 Pending	28a. DATE OF (Month, D		28b. TIME INJU	IRY	INJURY AT WORK?		8d. DEŞCRIBE NOW I	INJURY OCC	URED	
NG ING	E	5	2 Accident Investigation	200 81 405 0	F 101 11 11 11 11 11 11 11 11 11 11 11 11			YES 2 _					
SIC FEND OR: 4	28 is	3	3 Suicide 8 Could not be 4 Nomicide determined	building,	F INJURY — At hor atc. (Specify)	ne, farm, st	reet, factory, o	ffice	2	8f. LOCATION (Street City or Town, State)	and Number)	or Rural Ro	ute Number,
	E 2	,											
AL OR	If Item	MILLE	(Check only one)										
SPIT NER	ANTE	5	2 MEDICAL EXAMINE	R: On the basis of a	xamination and/or is	rveatigation	, in my opinio	n, death occurso	at the tir	ne, date and piece, ar	nd due to the	cause(a)	and menner as stated.
부 부 경	HTA.	u II	29b, SIGNATURE AND TITLE OF DESTRIPE	16	1			29c, LICEN	SE NUMB	ER	29d. DATE	SIGNED (Month, Day, Year)
TO THE HOSPITAL (TO THE FUNERAL D	IMPORTANT	\ I	1111		un			D 1	5804		1 6	-24	-95
	₹		30. NAME AND ADDRESS OF PERSON WH		SE OF DEATH (ITEM	27) (Type,	Print)		m1		017	20	
			Dr. Steven A.				iter St	treet	Thur	mont, MD	2178	38	
			31. DATE FILED (Month, Day, Year)	32. REGISTRA	ANS SIGNATURE		_						
			JUN 2 6 1995) James	marter 1	ball							



BALTIMORE, MARYLAND 21215-0020

HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	RECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should as after death with the State Deor, of Health and Mental Hydiene prior to burial, cremation, or removal.	m 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
to the Hospital or Attending Physic	TO THE FUNERAL DIRECTOR: After this ce be filed within 72 hours after death with the	IMPORTANT: If item 28 is marked,

													95	20737
	1 - FOR STATE REGISTRAR		STATE OF N	MARYLAND C	DEPAR					MENTA	L HYGIEN			
	1. DECEDENT'S NAME (First	, Middle, Last)					-				OF DEATN			3. TIME OF DEATH
	ROBERT		HAYES	WIS	SE					Ju	ne 9,1	995	YEAR	10:35 M
	4. SOCIAL SECURITY NUMBER	BER	5. SEX	6. AGE (In yrs. le	st birthday)	IF UND	ER 1 YEAR	IF UNDE	R 24 HRS.	7. DATE	OF BIRTH		B. BIRTH	IPLACE (State or Foreign
	213-42-09.	57	1 🙀 M 2 🗌 F	52	YRS.	MONTHS	DAYS	HOURS	MIN.		nth, Day, Year) Count Lary 2, 1943 Ma			ryland
	9a. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CIT	TY, TOWN	OR LOCATI	ON OF D					
H	316 Maplewa	ау				S	alis	bury					Wicc	omico
5	RESIDENCE OF DEC													
DIRECTOR	10e. STATE	10b. COUNTY					OR LOCA							10d. INSIDE CITY LIMITS?
	Maryland		icomico			Salı	sbur							1 K YES 2 NO
FUNERAL	10e. STREET AND NUMBER						10	f. ZIP COD						WHAT COUNTRY?
W	316 Mapleway								801				JSA	
3	11. MARITAL STATUS 1 Never Married 2	Married	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. AI	RMED NO	13	If yes, sp	CENDENT (OF HISPAI	NIC ORIGI	N? (Specify Yes Rican, atc.)	or No-	14. RACE Black	E — American Indian, k, White, atc.
BY	3 🛭 Widowed 4 🗆 Divorced IF YES, GIVE WAR OR DATES Navy							2 XNO					Speci	
	15. DEC	EDENT'S EDU	CATION		ECEDENT'S	IISHAL	OCCUPATION	ON		144	. KIND OF BU	PINEGOUN		nite
	(Specify onl	y highest grade		(Give kind of work done d				ost of worki	ng	1.00	. KIND OF BU	3114E33/114	DUSTRY	
COMPLETED	9	College (1-4 or 5		lachai	nic					Truc	k			
0	17. FATNER'S NAME (First, M	liddle, Last)						1a. MOT	NER'S NA	ME (First.	Middle, Maiden	Surname)		
ВС	Raymond	Frank	klin Wise					Ros				Chu	rch	
BE (19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	AlLING ADDRESS (Street and Number or Rural Floute Number, City or Town, State, Zip Code)								
բ	Rosa Lee Ad	dkins									Hill,			3
	20a. METHOD OF DISPOSIT	on 3 🗆 Remo	ovel from State	20b. PLACE cemetery, co						DAT			City or To	
- 2	Commellon 3 Removed from State Commellon 5 Other (Specify) Salisbury Crematory 6/12 Salisbury, MD													
	Holloway Funeral Home 501 Snow Hill Rd., Salisbury,MD 21801										21801			
	23. PART I. Enter the d ahook, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death)	eert fallure.	a.	ase on each line OR AS A CONSE	o. 'N	0/			Ing, aud	h aa cer	dlec or resp	ratory ar	reat,	Approximate Interval Between Onset and Death
CERTIFICATION	Sequentially list condit if any, leading to imme cause. Entar UNDERLY CAUSE (Disease or Inju that initiated eventa resulting in death) LAS	diete ING iry	c	(OR AS A CONSE										
PHYSICIAN: MEDICAL	PART II. Other algolitica	nt condition	s contributing to	death but not	reaulting	In the u	ınderlyin	g cause	given in	Part I.	24a. WAS AN PERFOR 1 YES 2	MED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ž Z	DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF DEA	ATH YE	ES 🔲	NO [UNC	ERTAI	N \square				1 YES 2 XNO
Y	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL		26. PLA	CE OF DEA									
Sic	1 TES 2 NO		HOSPITAL:	ER/Outpatient	3 🗆 DOA	OTHE 4 \Baselet	ER: ursing Hom	ne 5-y Re	aldenca	a 🗆 Othe	or (Specify)			
		Pending	28a. DATE OF (Month, D		28b. TIM	IE OF JURY M	28c. INJ WC	PRIC?	NO	28d. DE	SCRIBE NOW I	NJURY OC	CURED	
TED BY	3 Suicide a	Investigation Could not be determined	28e. PLACE O building,	F INJURY — At he atc. (Specify)	ome, ferm,	atreet, fe					ATION (Street or Town, State)	and Numbe	r or Rural F	Poute Number,
COMPLETED			CIAN: To the best of R: On the beals of e) and menner se stated.
O BE C	296. SSOCK SUMPLEMBETITLE							D3	ENSE NUI	MBER 53		29d. DAT	TE SIGNED	(Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

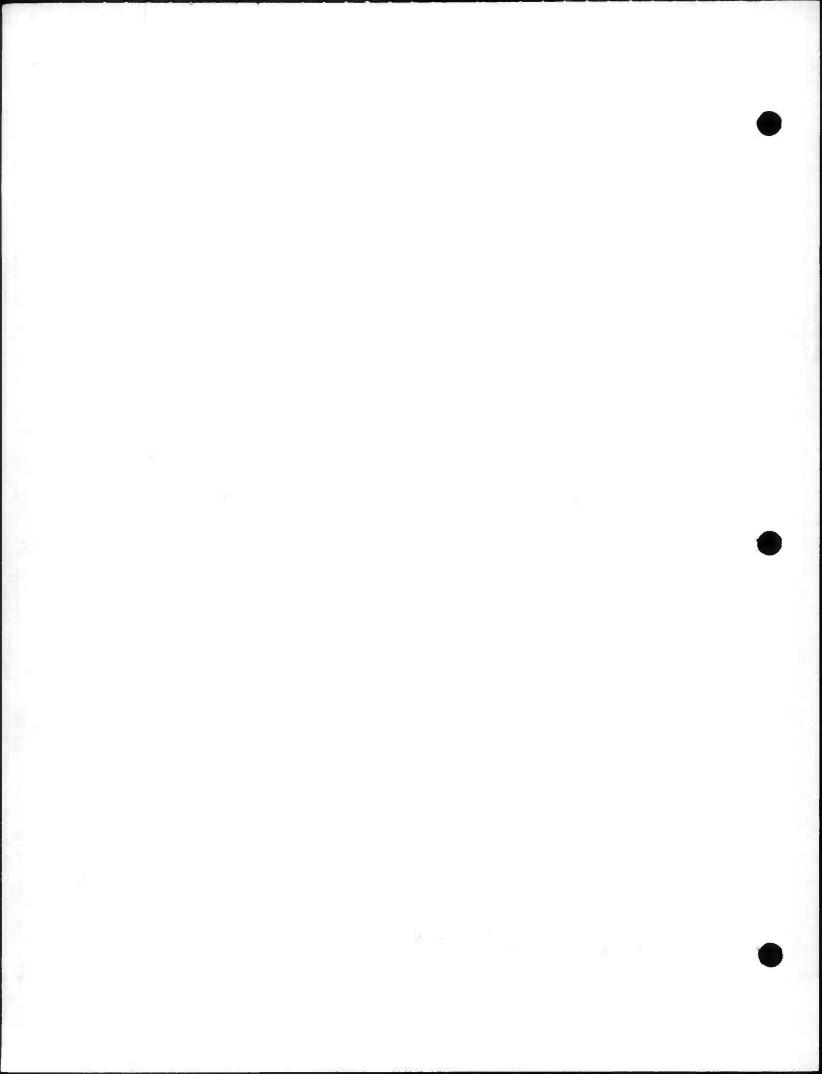
Rene Desmarais 560 Riverside Dr., Salisbury, MD

(410) 543-2255

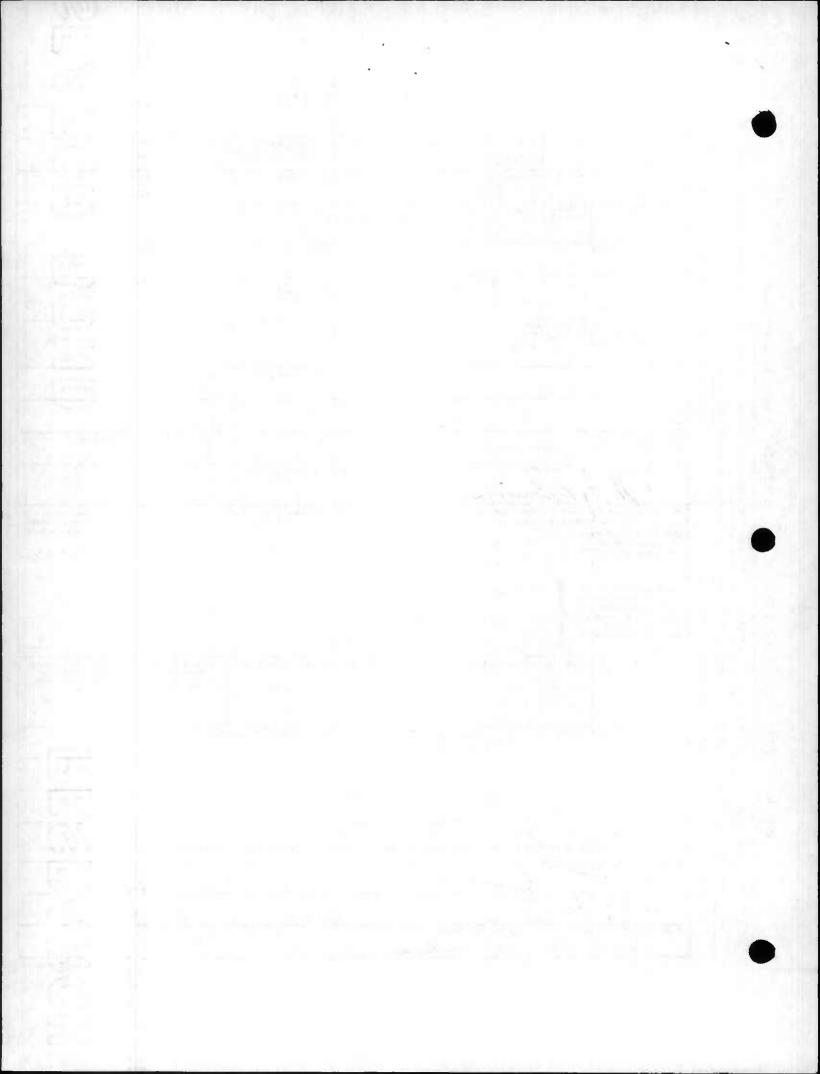
31. DATE FILED (Morith, Day, Year)

JUN 13 1995





	REGISTRAR		CERTIF	FICATE C	OF DEATH		REG. NO.				
- (1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATH H DAY	УЕАЛ	3. TIME OF DEATH		
- 1	Cora Eunice W					6	16	95	10:50		
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YE			OF BIRTH	8. BIRTHS	PLACE (State or Fon		
	215-46-2311	1 M 2 KF	94 YRS.	I WONTING	TOURS MIN.	3/1			MD		
	9a. FACILITY NAME (If not institution, give				WN OR LOCATION OF E	EATH	90, 0	COUNTY OF DE	HTA		
CTOR	Atlantic Gener	al Hospital		Ber	din		1	Norces'	ter		
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT										
DIRE	Legalitics Company of the company		10c. CI	TY, TOWN OR L					10d. INSIDE CITY LIMITS?		
		orcester		Ber					1 X YES 2		
₹	10e. STREET AND NUMBER				101. ZIP CODE		10g.		HAT COUNTRY?		
9	1 Meadow St.				21811			USA	LLM1		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. ARMED		DECENDENT OF HISPA				- American India White, etc.		
BY	1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR			YES 2 XND Spec			Specify			
				1					Wille		
밀	15. DECEDENT'S EDU (Specify only highest grade		16a. DECEDENT'S	work done durin	PATION g most of working	16b	. KIND OF BUSINESS	S/INDUSTRY			
4	Elementary/Secondary (0-12)	College (1-4 or 5+)	House	wife/Mo	other		Home				
COMPLET	11										
8	17. FATHER'S NAME (First, Middle, Last)						Middle, Meiden Surnen				
BE	John W. Knowle	es					telle Disr		1100		
2	19e. INFORMANT'S NAME (Type/Print)				eet and Number or Rura			a, Zip Code)			
-	Rachel Morgret		17 L	ord Gu	y Terrac	e Bei	rlin, MD	21811			
	20e, METHOD OF DISPOSITION 1 DA Burial 2 Cremation 3 Rem		D. PLACE AND DATE			DAT	E 20c. LOCATION	N — City or Tov	rn, State		
	4 Donation 6 Other (Specify)	TOTAL TOTAL STATE	Fort Line	coln Ce	emetery	6/22	/95 Bren	twood,	MD		
	21. SIDNATURE OF CUIVERAL RERVICE LI	CENSEE		22. NAW	E AND ADDRESS OF F	ACILITY	li i de la constitución de la co	F	1 11		
	Burbage Funeral F 108 Williams St. Berlin, MD 2181										
-	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, Approx										
	shock, or heart failure.	List only one cause on	each line.	not anter the	mode of dying, su	ch as can	diec or respiratory	y arrest,	Approxim		
	IMMEDIATE CAUSE (Final				4-				Onset and		
	disease or condition resulting in death)	a. Mac Cla	del	12/1	10/12/				10		
		DUE TO (OR AS	A CONSEQUENCE	OF):							
z l	Sequentially list conditions,	b									
CATION	If any, leading to immediate	OUE TO (OR AS	A CONSEDUENCE	DF):							
2	CAUSE (Disease or Injury	C									
CERTIFI	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE (OF):							
EH		d									
_	PART II. Other eignificant condition	na contributing to death	but not resulting	in the under	lying cause given in	Part I.	24s. WAS AN AUTO	PSY 24b.	WERE AUTOPSY F		
EDICAL							PERFORMED?		AWAILABLE PRIOR		
						_	1 TYES 2 N	0	OF DEATH?		
Σ						_		1119	1 YE\$ 2		
Z											
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:	6. PLACE DF DEATH (C	heck only or	10)				
YS	1 YES 2 NO	1 npetient 2 ER/Ou			Home 6 - Residence	6 🗆 Othe	or (Specify)				
РНУ	27. MANNER OF DEATH	(Month, Day, Year)	26b. TII	ME OF 280	WORK?	28d. DE:	SCRIBE HOW INJURY	OCCURED			
B	1 Netural 6 Pending 2 Accident Investigation		100	M 1	YES 2 NO						
	3 Suicide 6 Could not be	28e. PLACE OF INJUR building, etc. (Sp	RY — At home, farm, pecify)	street, factory,	office		ATION (Street end Nu or Town, State)	mber or Rural R	oute Number,		
TE	4 Homicide determined						,				
COMPLETED	29e. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the best of my kno	wiedge, death occur	red at the time.	date end place, end du	e to the ce	use(e) and manner as	stated.	11/1/2		
M		ER: Dn the basis of examinat							end menner ee		
8											
BE	296. SIGNATURE AND TITLE OF CERTIFIE	.//	Service Contract of the Contra		29c. LICENSE NO	JMBER	29d.	DATE SIGNED	(Month, Day, Year)		
2	100	1			H44	433		6/1	6155		
	20. NAME AND ADDRESS OF PERSON WI		DEATH (ITEM 27) (Typ	e, Print)	2 0						
1	9733 6	Helthway	Drive		Serke	MD	218	((E. Lies		
0	31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S SIG	SNATURE								
6	JUN 2 1 1995	32 REGISTRAR'S SIG						0			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 12 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

HEGISTHAN			EKIIF	ICALL	= OF	DEATH	R	EG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF C			3. TIME OF DEATN	
James	Allan				Wats	n, Sr.	June 21	, 1995	YEAR	1725	
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I	lest birthday)	IF UNDER	1 YEAR	IF UNDER 24 HRS.	7. DATE OF B	IRTN	8. BIRTI	PLACE (State or Foreign	
578-24-4545	1 M 2 F	70	YRS.	MONTHS	DAYS	HOURS MIN.	Jiilv 9	, 1924	Wash	ington,DC	
9e. FACILITY NAME (If not institution, give	street end number)			9b. CITY,	TOWN C	R LOCATION OF D			COUNTY OF D		
Calvert Memorial	Hospital			Pr	ince	Freder	ick		Calvert		
RESIDENCE OF DECEDENT				11	THE	. rreder.	ICK		Calve	IL	
10e. STATE 10b. COUNT	TY		t0c, CIT	Y, TOWN O	R LOCAT	ION				10d. INSIDE CITY LIMITS?	
Maryland C	alvert			Lu	sby					1 YES X NO	
10e. STREET AND NUMBER					101.	ZIP CODE		100	. CITIZEN OF	WHAT COUNTRY?	
P.O. Box 612 5	12 Thunder	bird D	rive			20657				USA	
tt. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. A	PMED	13. 1	WAS DEC	ENDENT OF NISPA	NIC ORIGIN? (Sp	ecify Yee or N	0 14. RACI	- American Indian.	
1 Never Merried 2 Married	FORCES? 1)	R OR DATES]NO		f yes, spe	2 NO Speci	an, Puerto Rican %:	, atc.)	Sono	k, White, etc.	
3 Widowed 4 Divorced	W.W.	II				42	,.		1	White	
15. DECEDENT'S EDI (Specify only highest grad	JCATION e completed)	18e. D	ECEDENT'S	USUAL OC	CCUPATIO	N et of working	16b. KINI	OF BUSINES			
Elementary/Secondary (0-12)	College (1-4 or 5+)		fe. Do NOT us	e retired.)	auting mod	a or working					
11th			Sale	sman			Au	tomobi	les, T	rucks	
17. FATNER'S NAME (First, Middle, Last)						18. MOTNER'S NA					
John	n William	Watson	l			Ethe	el G. F	riel			
19e. INFORMANT'S NAME (Type/Print)		1	9b. MAILING	ADDRESS	(Street a	nd Number or Rural			te, Zip Code)		
Earline D. Watso	on					Lusby Ma					
209, METHOD OF DISPOSITION 1, District 2 Cremetion 3 Rem		20b. PLACE	F AND DATE (OF DISPOS	ITION /Na	me of	DATE	20c LOCATIO	N - City of To	wn State	
1 1 NBuriel 2 □ Cremetion 3 □ Ren 4 □ Donetion 5 □ Other (Specify)	noval from State	cemetery, c	remetory or or	ver place)	ran f	s Com 6	3-26-95	Chal	tonham	Maryland	
21. MIONATURE OF PUMERAL BERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home									, marytanu		
23. PART I. Enter the diseases, or	8			6	160	Oxon Hil	L1 Rd.	Oxon H	i11, M	d. 20745	
shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. BRAINS	TEM OR AS A CONS	STRO.							interval Batweer Onset and Deatl	
Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b. PFRIPP DUE TO (0	OR AS A CONSI			L D)ISFASE					
PART II. Other significant condition	ns contributing to d	leath but not	reaulting i	n the un	derlying	cause given in	Part I. 24a.	WAS AN AUTO	PSY 24b	WERE AUTOPSY FINDINGS	
ACUTE MYOCAR DIALS	AFARETIAN.	-00EVI	ous le	CIFA	TO.	20.000	, ,	PERFORMED?		AMILABLE PRIOR TO COMPLETION OF CAUSE	
APREST DUE TO	And was a	05.70.0		24 6	- / -	7 / 00 7		YES 2	0	OF DEATH?	
DID TOPACCO LISE CONT	DIDLITE TO CAL	ICE OF DE	ATLL VE	3/ /	JANE J	(50 0)				t YES 2 NO	
DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	T T CAC		ATT TE			UNCERIAL	N L			4 4 4	
EXAMINER?	HOSPITAL:			OTHER	t:						
1 YES 2 NO	t 🗅 Thpatient 2 🗆		1	77.		5 Residence	6 Other (Spe	ocify)			
27. MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF II (Month, De)		28b. TIM	E OF URY	28c. INJU WOI	IRY AT RK?	26d, DESCRIB	E HOW INJURY	Y OCCURED		
2 Accident Investigation				M		ES 2 NO					
3 Suicide 6 Could not be 4 Homicide datermined	28e. PLACE OF building, e	INJURY — At h tc. (Specify)	nome, term, s	treet, facto	ory, office		281. LOCATION City or Tou	(Street end Nu vn, Stete)	imber or Rural F	loute Number,	
29e. CERTIFIER t CERTIFYING PNYS	ICIAN: To the best of m	ny knowledge, d	leath occurre	d at the fir	me, date	and place, end due	to the cause(e)	and manner a	e stated		
one) 2 MEDICAL EXAMIN										end menner as stated	
29b. SIGNATURE AND TITLE OF CERTIFIE					1						
AND SIGNATURE AND SITE OF CENTIFIE	Word.				}	29c. LICENSE NUI	-			(Month, Day, Year)	
1/h H	11201/	~)				DJ 6.	358		JUM-	21, 1995	
30. NAME AND ADDRESS OF PERSON WI		OF DEATH (IT	EM 27) (Type,	Print)							
Dr. Weigel Prince Fre	derick, Má.										
31. DATE FILED (Month, Day, Year)	32 REGISTRAR	'S SIGNATURE	1 10								
JUN 23 1995	Masia dia	adicocide in	roall								

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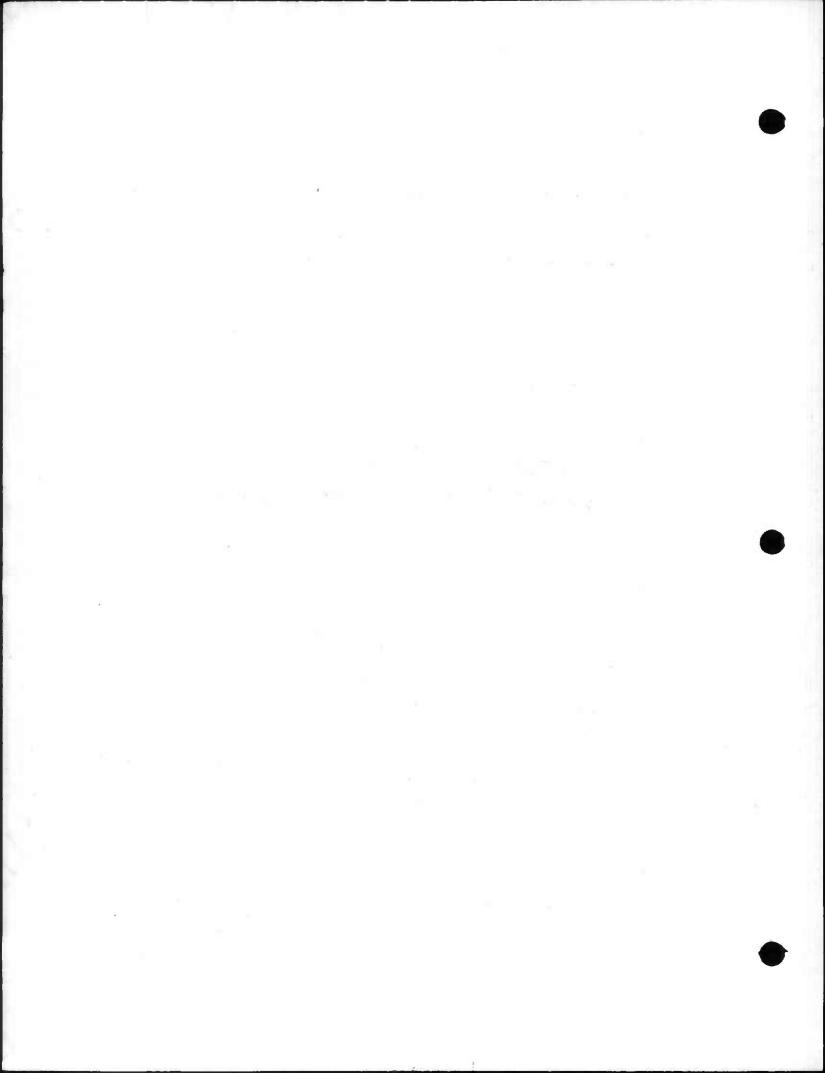
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BALTIMORE, MARYLAND 21215-0020	24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hyplene prior to burial, cremation, or removal.	he medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HIGH WAY DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fun- be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCICAE

	1 - STATE REGISTRAR	0	CE	RTIF	ICATE OF	DEATH	MENIAL	REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)					D 47	2. DATE O	DEATH			3. TIME OF DEA	ATH
	LAURA LY	'NN	WOLFF					JUNE 13 1995 9:34				Рм
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF		12 1		PLACE (State or I	
	214-86-5828	Atom Co. W						065	Country	γ)	Oreign	
	9a. FACILITY NAME (If not institution, give st	21			AL OUTY TOWN	OR LOCATION OF		/, 1			yland	
œ							DEATH			UNTY OF D		
임	PRINCE GEORGES HOSPITAL CENTER CHEVERLY PRINCE								GEOR	GES		
E I	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCA	TION		10d. INSIDE CIT				γ	
告	Marvland Prince	e George		Rv	entwood	n. li					LIMITS?	
4	10e. STREET AND NUMBER	e George	3	DI		1, ZIP CODE			100 CD	TIZEN OF W	HAT COUNTRY?	
7	3700 Bladensburg	Road #1	5		100	20722					States	
FUNERAL DIRECTOR	11. MARITAL STATUS	12. WAS DECEDENT		MED		ENDENT OF HISP	ANIC ODIGINS	Canally Vo				
E	1 X Never Married 2 Married	FORCES? 1 IF YES, GIVE W	YES 2 X N	0	If yes, sp	ecify Cuban, Maxi	can, Puarto Ric	an, etc.)	O 110	Black	— American Ind , White, atc.	man,
В	3 Widowed 4 Divorced	ii res, dive ii	AN ON DRIES		I U YES	2 X NO Spec	ony:			Specif	White	
8	15. DECEDENT'S EDUC	ATION	16a. DEC	EDENT'S	USUAL OCCUPATE	DN	18b. K	ND OF BU	SINESS/IN	DUSTRY		
12	(Specify only highest grade	College (1-4 or 5 +	(Given life.	ne kind of a Do NOT us	vork done during mo e retired.)	ost of working						
릴	12			ecke	r		Fo	od Ir	idust	trv		
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)					16. MOTHER'S						
ш	Edward P. Wolff,	Sr.				Doris	Ann Em	ersor	1			
9	19a. INFORMANT'S NAME (Type/Print)		19b	MAILING	ADDRESS (Street I				_	ip Code)		
임	Doris A. Stine				Bladensl						20722	
	20a. METHOD OF DISPOSITION		20h PLACE A	NO DATE	E DISPOSITION (N	ame of	DATE	200 10	CATION	Olive on You	un Otata	
	1 X Burial 2 Cremation 3 Ramo	wal from Stata	Fort	Line	coln Cem	eterv	6/20/9	Br	entw	ood.	Marvla	nd
	21, SIGNATURE OF FUNERAL SERVICE LICE	pries /			22, NAME A	ND ADDRESS OF	ACILITY				nar y rai	ii d
	•	//-	/,		Fort I	incoln	Funera	1 Hon	ne, I	Inc.		
-	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate											
	shock, or haart fallure. L	ist only one cau	caused the dea se on each line.	ith. Do r	ot enter the mo	de of dying, au	ch aa cardia	c or respi	ratory er	rrest,	Approxin	
	IMMEDIATE CAUSE (Final disease or condition	Λ	A . II .	A	(14	106	1			Onset an	
	resulting in dasth)		WILL	VIL	- 19ch	STON	140	ma	5			
		DUE TO	OR AS A CONSEQ	PENCE OF	7: (
CERTIFICATION	Sequentially list conditions,	DUE TO	OR AS A CONSEQ	UENOE O								
F	if any, leading to immediata cause. Entar UNDERLYING	502 10 (OH AS A CONSECU	DENCE OF	·);							
윤	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONSEQ	UENCE OF	٦٠							
Ē	resulting in death) LAST										İ	
8											1	
DICAL	PART il. Other aignificant conditions	contributing to	death but not re	suiting i	n the underlyin	g causa given i	n Part i. 2	la. WAS AN		24b.	WERE AUTOPSY	
8							1	PERFOR			AVAILABLE PRIOR	
ME											1 YES 2	MO
=	DID TOBACCO USE CONTR	IBUTE TO CAL	JSE OF DEAT	H YE	S I NO I	UNCERTA	IN []				1000	
Ĭ.	25. WAS CASE REFERRED TO MEDICAL				H (Check only one)							
Sic		HOSPITAL: 1 ☐ Inpetient 2 ☐	ER/Outpatient 3	DOA	OTHER:	s 5 🗆 Besidense	6 🗆 Other (S	anath.				
PHYSICIAN:	27. MANNER OF DEATH	26a DATE OF	MILIDY	28b. TIM	OF 28c, INJ	URY AT	28d. DESC		NJURY OC	CURED	2 /	
	1 Natural 5 Pending	(Mont), Da	2/9	2/21	DRY WO	RK?	7	h	4	1-6	1	
B	2 Accident Investigation 3 Suicide & Could get be	28a. PLACE OF	NJURY At hor	ne, tarm, a			28f LOCATI	ON (Street a	and Number	or Burni B	oute Number.	
Ë	Homicide 6 Could not be determined	bullding, a	itc. (Specify)	150			City or	own, State)	1	المدا	A A	-
9	29a. CERTIFIER					SANCE ALL DIVER	1304	5 61	. 94		47	2
COMPLETED	(Check only one)											
8	One) ZMEDICAL EXAMINER		minimum and/or in	vestigatio	n, in my opinion, a	eath occured at th	e time, date an	d place, an	d dua to t	he cause(a)	end manner as	stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER	1	Da 1	1		29c. LICENSE NO					(Month, Day, Year)	
2	20 MANGANO COLOR	- 0	rep	7		O.C.N	1.E.		₽JU	NE 1	14,199	ס
	30. NAME AND ADDRESS OF PERSON WHO	CA 15 A	11							,		,
	JUNEON CO	10/12		Pen	n Stree	et, Bal	Ltimor	e, l	Mary	Tand	1 2120	1
11	24 DATE PHED MANY CO											
	JUN 21 1995	32. REGISTRAF	S SIGNATURE									

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DIVISION OF VITAL RECORDS, P.O. BOX

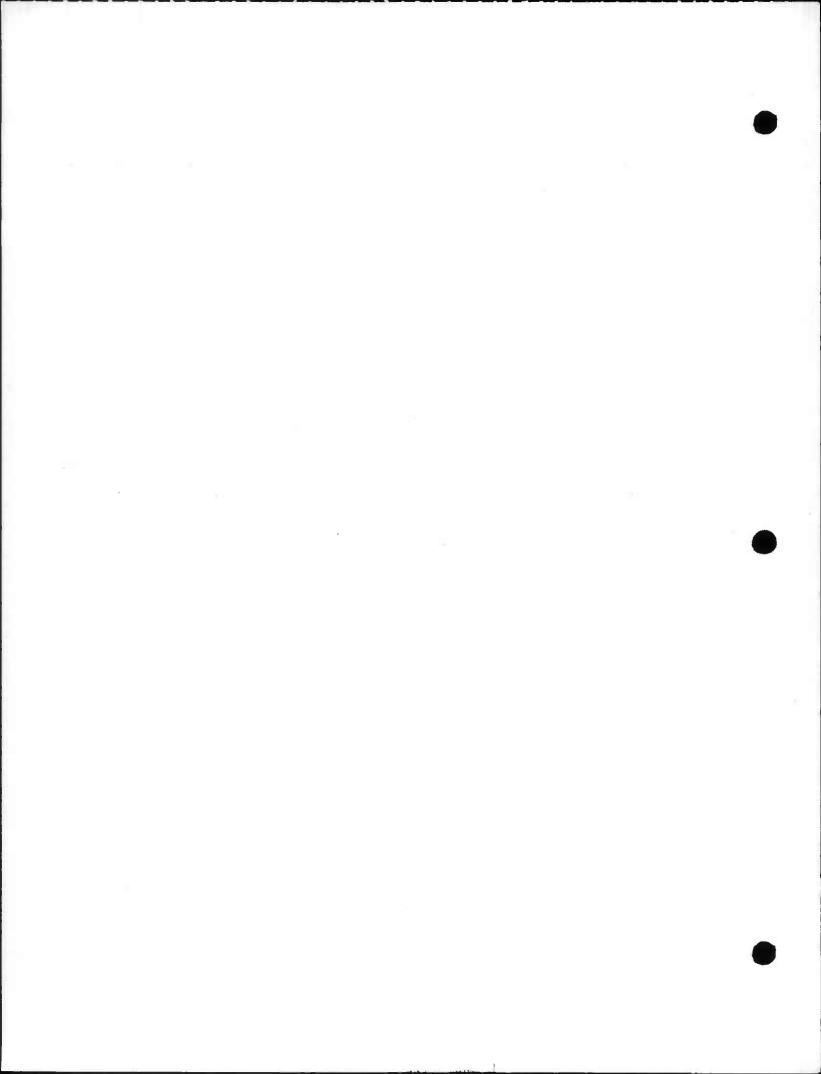
TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

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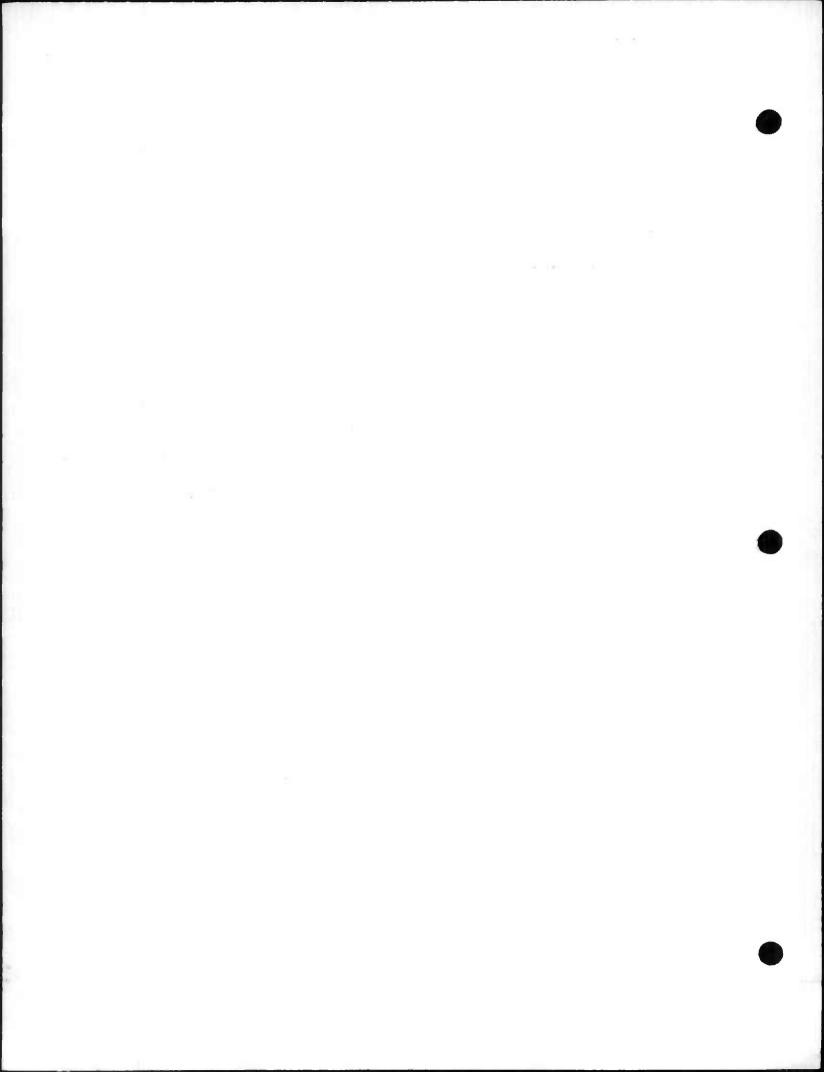
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARY		MENT OF HEA		NTAL HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle,	Last)				DATE OF OEATN		3. TIME OF DEATN		
- 1	Maria T. W	illiams			J	MONTH 15	1995	11:00 рм		
	4. SOCIAL SECURITY NUMBER	CURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTY 6. BIRTYPE								
1	220-60-5481	MONTHS DAYS HOURS MIN. (Month, Day, Year)								
	9e. FACILITY NAME (If not institution,			. CITY, TOWN OR L	OCATION OF DEATN		9c. COUNTY OF	ryland OEATN		
DIRECTOR	Anne Arundel M	Anne Ar								
EC	10e. STATE 10b. CC	OUNTY	10c. CITY, T	OWN OR LOCATION				10d. INSIDE CITY		
5	Maryland Ann	e Arundel	Edge	water				LIMITS?		
FUNERAL	10e. STREET AND NUMBER		1 4-		CODE		10g. CITIZEN OF	WNAT COUNTRY?		
ER	1644 Bay Ridge	Road		21	037		USA			
5	11. MARITAL STATUS	12. WAS DECEDENT EVER		13. WAS DECEND	ENT OF HISPANIC	ORIGIN? (Specify Yee o	r No- 14. RAC	CE — American Indian,		
	1 Never Married 2 Merried	FORCES? 1 YES			Cuban, Mexican, P. NO Specify:	uerto Rican, etc.)	Spe	ck, White, etc.		
ВУ	3 Widowed 4 Divorced	No		_ ×	X.			hite		
COMPLETED	15. DECEDENT'S (Specify only highest	B EDUCATION grade completed)	18e. OECEDENT'S USI	done during most of	working	16b. KIND OF BUSIN	NESS/INDUSTRY			
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT usa re	tired.)						
MP	12	2	Electronic	s Techni	ician	Allied S	Signal			
8	17. FATHER'S NAME (First, Middle, Las			18.	MOTHER'S NAME	(First, Middle, Maiden St	imeme)			
BE	Daniel V. Coff					K. Dillon				
5	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street end A	lumber or Rural Route	e Number, City or Town,	State, Zip Code)			
-	William R. Wil	liams	1644 Bay	7 Ridge H	Road Edge	ewater, Mo	1. 2103	7		
	20e. METNOD OF DISPOSITION 1 □ Buriel 2 T Cremetion 3 □	Removal from State CB	netery, cremetory or other	nlace)			TION — City or 1			
	1 □ Buriel 2 ☆ Cremation 3 □ 4 □ Donation 5 □ Other (Specify)	12.2	tropolita	n Cremate	ory 6-1	7-95 Alexa	andria,	Virginia		
	21. SIGNATURE OF FUNERAL SERVICE			Robert	DORESS OF FACILITY	Funeral	Home, P	. A.		
_ {	Kohert E. S	Evans; Pres				Road Bow				
	23. PART i. Enter the diseeses	, or complications that cause	d the deeth. Do not	enter the mode	of dying, such e	s cerdlec or reepire	tory arrest,	Approximate		
	The second secon	lure. List only one cause on	ech line.	~	\ /	A		Interval Between Onset and Death		
	IMMEDIATE CAUSE (Final disease or condition resulting in death)									
	resulting in death)	DUE TO (OR AS	A CONSEQUENCE OF):	1510	. (3(0(00)		- 141-2		
z										
은	Sequantially list conditione, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE OF):							
CERTIFICATION	cause. Entar UNDERLYING CAUSE (Disease or Injury	C								
E	that initiated events	DUE TO (OR AS	A CONSEQUENCE OF):							
	resulting in desth) LAST	d								
	PART II. Other significant cond	ditions contributing to death	out not resulting in t	he underlying on	use alven in Par	t i. 24s. WAS AN AL	ITOBEV	b. WERE AUTOPSY FINDINGS		
SAL			out not resulting in t	ne underlying ce	use given in rei	PERFORM		AVAILABLE PRIOR TO		
						1 🗆 YES 2 [NO	OF DEATH?		
Σ	DID TOD 4 660 1167 66							1 TYES 2 NO		
PHYSICIAN: MEDIC	DID TOBACCO USE CO	ONTRIBUTE TO CAUSE O			UNCERTAIN [
S.	EXAMINER?	HOSPITAL:	26. PLACE OF DEATH (THER:						
14S	1 TYES 2 NO	1 Inpetient 2 ER/Out		Nursing Home 5	Residence 8					
	Netural 5 Pending	(Month, Day, Year)	28b. TIME O	WORK?		d. DEŞCRIBE HOW INJ	URY OCCURED			
B	2 Accident Investiga		/ — At home, farm, stree	M 1 TYES	2 NO	1.10017101110111011				
ED	3 Suicide 8 Could no 4 Hornicide determin	building, atc. (Spe	cify)	n, ractory, ornea	20	f. LOCATION (Street and City or Town, State)	a Number or Hural	Houte Number,		
COMPLET	29e. CERTIFIER									
MP	(Check only	PHYSICIAN: To the beat of my know						agent the same of the same of		
0	MEDICAL EX	AMINER: On the beele of exemination	n end/or investigation, is	n my opinion, death	occured at the time	e, date end place, end	due to the cause	(e) and menner es stated.		
BE (THE SIGNATURE AND TITLE OF CER	THER 111		29	CHCENSE NUMBER	11	Md. DATE SIGNE	D (Month Day, Year)		
5 B	Jack Jack	Mark M	1)		NOS	04	6	17195		
	30. NAME AND ADDRESS OF PERSO	N WHO COMPLITED CAUSE OF DE	ATH (ITEM 27) (Type, Pri	(11)	1	11.0	101	101		
	JOD1884	sale 19	D # 50	UMN	NOLPOI	us my	2 LC	401		
	31. DATE FILED (Month, Day, Year) JUN 21 1995	32 REGISTRAR'S SIGN	ATURE					7		
	3014 WT 1939							J		

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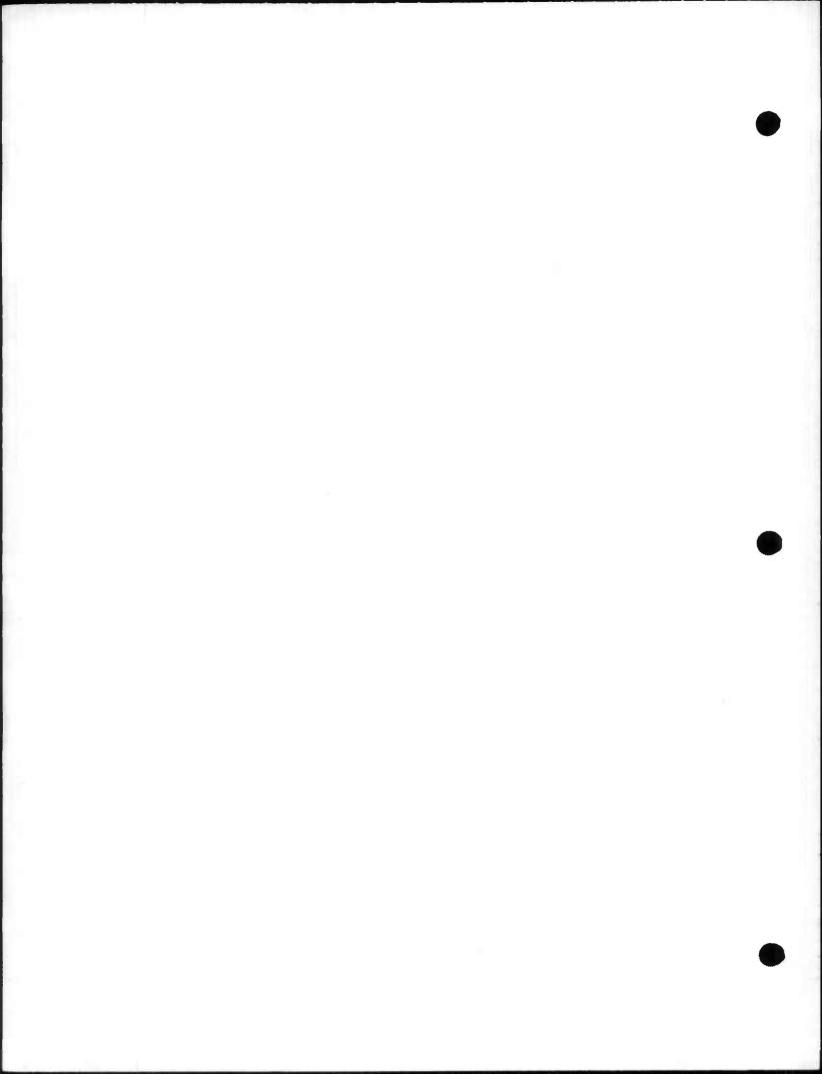
	_	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.
		1. DECEDENT'S NAME (First, Middle, Leet) AMES / BUSY WADDY 2. DATE OF DEATH MONTH DAY 9 SAR 3. TIME OF DEATH MONTH DAY 9 SAR 3: 19 P
3 should		4. SOCIAL SECURITY NUMBER 5. SEX 1 M 2 F 6. AGE (in yrs. last birthday) F UNDER 1 YEAR F UNDER 14 HRS. 7. DATE OF BIRTH (Month, Dey, Year) May Ch 6 1934 F UNDER 14 HRS. 7. DATE OF BIRTHPLACE (State or Foreign Country) Wash., DC 96. FACILITY NAME (if not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 99. COUNTY OF DEATH
N,	CTOR	HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY
020 physician. burial-transit permit. Pages 1,	DIREC	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Washington, D.C. 11√ YES 2 □ NO
sit perm	FUNERAL	106. STREET AND NUMBER 107. ZIP CODE 109. CITIZEN OF WHAT COUNTRY?
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-tran	BY FUNE	11. MARITAL STATUS 1 Never Merried 2 Merried 1 Never Merried 2 Merried 1 Never Merried 2 Merried 1 Never Merried 2 Merried 1 Never Merried 3 Wildowed 4 Divorced 1 VES QIVE WAR OR DATES 1 VES QV NO Specify: Specif
21215- ital or attendii	G	Black
MARYLAND retained by the hospit 5 should be detached	BE COMPLET	12 Truck Driver Trucking 17. FATHER'S NAME (First, Middle, Last) Walter Waddy Addie Swingian
B, MAR) by be retained by be retained by be should	TO BI	19a. INFORMANT'S NAME (TyperPrint) Addie Waddy 19b. MAILING ADDRESS (Street end Number or Rural Poute Number, City or Town, State, Zip Code) 220 R St., NE Wash., DC 20002
AORI je 6 may rector, p	E E	206. METHOD OF DISPOSITION 1 A Burlei 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) 206. PLACE AND DATE OF DISPOSITION (Name of 5/18/6) 206. LOCATION — City or Town, State Cemelety, cremetory, of other place of Cedar Hill Cemetery 3—18—95 Suitland, Md.
~ ~ E	examine	22. NAME AND ADDRESS OF FACILITY Capitol Mortuary 1425 Maryland Ave., NE Wash., DC
lety filled in the nation, or ref	event, the medical	23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ahock, or heart failure List only one cause on each line. Approximate interval Betwee Onset and Deat disease or condition a. Due to for as a consequence of
.O. BOX 687(certificate be executed ding physician and con lygiene prior to burial,	ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
ORDS that the d ed by the	OICAL C	PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. Other algnificent co
- co co co	IN: ME	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN
F # 9 #	SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)
〇 光 精美	- T	27. MANNER OF DEATH 26a. DATE OF INJURY 26b. TIME OF INJURY AT WORK? 26c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCUREO 26d. DESCRIBE HOW INJU
TISI STOR: after	· W	3 Suicide 4 Homicide Could not be determined Could not be determined Could not be determined See PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) City or Town, State)
4 12 =		29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
TO THE HOSPIT TO THE FUNERA be filed within 7	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Morifin, Day, Year) 5/1//35
(1)		830 Consunto Onive Condus MP 36785
10		JUN 201995 July Daubler Royall



1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO

		4 DECEMBER OF A AND A AN		CERTIF	ICATE	JF DEATH	REG. NO).		
		1. DECEDENT'S NAME (First, Middle, Last) LORIELE			WOOD	SON	2. DATE OF DEATH	DAY 1995 YE	S. TIME OF DEATH	
7.		4. SOCIAL SECURITY NUMBER N/A	5. SEX 6.	AGE (In yrs. last birthday) YRS.	IF UNDER 1 YE	YS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Yber)	8.	BIRTHPLACE (State or Foreign	
Pin		9a. FACILITY NAME (If not institution, give s	direct and sumbard			1 122		-	IARYLAND	
2, 3 should	DIRECTOR	HOLY CROSS RESIDENCE OF DECEDENT	HOSPITAL					9c. COUNTY	OF DEATH	
85 —	ပ္ပ	10a. STATE 10b. COUNT	ν	140- 017	Y, TOWN OR L	2017:011				
permit, Pages		MARYLAND		100, 01		MAHV			10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
15	ERAL	106. STREET AND NUMBER 9929 GREENBELT ROAD, #102 107. ZIP CODE 109. CITIZEN OF U.							J.S.A.	
al-tra	FUN	11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S.ARMED	13. WAS	DECENDENT OF HISPAI	NIC ORIGIN? (Specify Ye		RACE — American Indian,	
1 2 a	BY	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	YES 2 NO OR DATES	If ye	s, specify Cuban, Mexico YES 2X NO Specif	en, Puerto Ricen, etc.)		Black, White, etc. Specify: BLACK		
affend use as	유	15. DECEDENT'S EDU	CATION	18a. DECEDENT'S	USUAL OCCU	PATION	16b. KIND OF BU	JSINESS/INDUST		
hospital or a ached for us	COMPLET	(Specify only highest grade	College (1-4 or 5+)	life. Do NOT us	work done durin se retired.) /A	g most of working		N/A		
he hospit detached	8	17. FATHER'S NAME (First, Middle, Last)								
3 B B B	BE CC	DAMON		WILLI		KEIA	ME (First, Middle, Maider	V	WOODSON	
retained by 5 should b	5	190. INFORMANT'S NAME (Type/Print) KEIA WOODSON				eet and Number or Rural				
be on the		20a. METHOD OF DISPOSITION		20b. PLACE AND DATE		BELT RD.				
E e e		1 Deriel 2A Cremation 3 Rem 4 Donation 5 Other (Specify)		cemetery, crematory or o	ther place)		6-	ELTSV	ILLE, MD	
leath. Pag funeral of xaminer		21. SIGNATURE OF FUNERAL SERVICE LA	CENSES ((0 0	22. NAM	LOR'S F	CILITY	НОМЕ		
0 2 0		Melic N	Strick	Eland					W WASH . DC	
ours after d d in by the or removal.		23. PART I. Enter the diseeses, or	complications that c	aused the deeth. Do i	not enter the	mode of dying, auc	h as cerdiec or resp	olratory arreat	, Approximata	
		ahock, or haart failura. IMMEDIATE CAUSE (Finel	List only one cause	on each lina.				S-S-1 FILM	Interval Batween Onset and Death	
1 章 5 章		disease or condition Extreme was to the first and bearing the condition of								
completely file ial, cremation.		disease or condition reaulting in deeth) a. Extreme immaturity Due to (or as a consequence of): 1/2 hrs.								
- 5 6 E	2									
e be execut sician and c rifor to buri	RTIFICATION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):								
ficate be ophysician ne prior to	8	Cause. Enter UNDERLYING CAUSE (Disease or Injury								
	ᄩ	that Initiated eventa DUE TO (OR AS A CONSEQUENCE OF):								
F 6 5 0	ш	resulting In death) LAST	d							
0 0 =	0	PART II. Other aignificant condition	a contributing to de	ath hut and annulation	la the sector					
1 20 1	₹ I	THIS II. Other algument condition	e contributing to de	eth out not resulting	in the under	lying ceuse given in	Part I. 24e. WAS AN PERFO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
signed by Health and	EDICAL						1 _ YES :	2 1 NO	OF DEATH?	
	Σ	DID TODA CCO LICE COATE	DIDLITT TO CALL			_/			1 TYES 2 -NO	
The law req ate has been ate Dept. of	AN:	DID TOBACCO USE CONTI	RIBUTE TO CAUS				N 🗆 📗			
e ate at	SICI	EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	OTHER:	11.3				
iclay the the	ı >- I	27. MANNER QE DEATH	28a. DATE OF IN.	R/Outpatient 3 DOA		Home 5 Residence				
The state of	У РН	1 Natural 5 Pending	(Month, Day,	JURY Year) 28b. TIM	URY	INJURY AT WORK?	28d. DESCRIBE HOW	INJURY OCCUR	ED	
WDING Her death	D BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF IN	UJURY At home, ferm, r	street, fectory,		281. LOCATION (Street	and Number or F	Burat Route Number	
2 H 6 # 8	2	4 Homicide determined	building, atc.	. (Specify)			City or Town, State)		
	MPLE	29e. CERTIFIER 1 CERTIFYING PHYSI	ICIAN: To the best of my	knowledge, death occurr	ed at the time	data and place, and due	in the councies and me	anar as stated		
토 경 전 보	M								suse(a) end menner as stated.	
HOSPI FUNEF within	8	29b. SIGNATURE AND TITLE OF CERTIFIE								
TO THE HOSPI TO THE FUNEF be filed within	BE	Katheine Cla	Khite Ur	Staff No	oustolog	29c. LICENSE NUM	137	DATE SI	SNED (Month, Day, Year)	
₽ ₽ ₽ ₹	2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE	OF DEATH (ITEM 27) (Type	Print)	11 1 20	177	1 07	0/13	
(1)		Kathenne C. Who	ite MD.	Holy Cross	Hosp	1500 F	restblen	Rd. S.	il. Spg 20910	
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S	SIGNATURE	1				, ,	
		TOUT TO 1000	7 - you was	- THE COLOR						

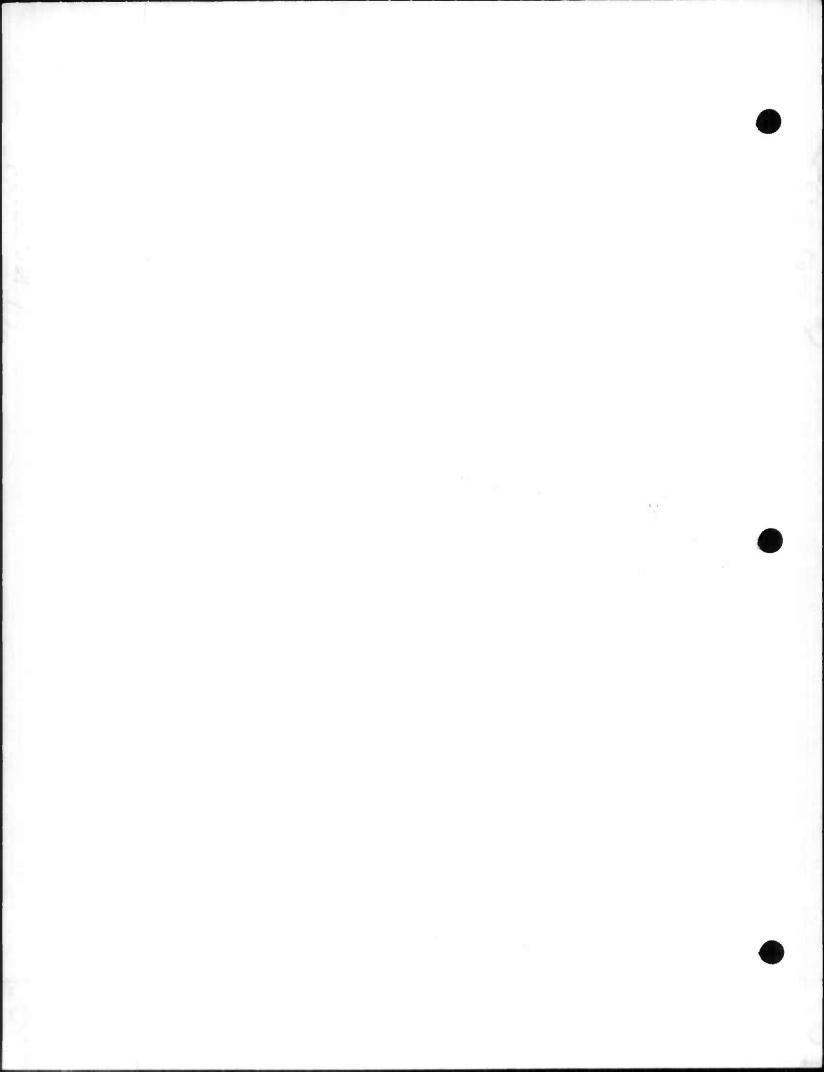


spital or attending physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

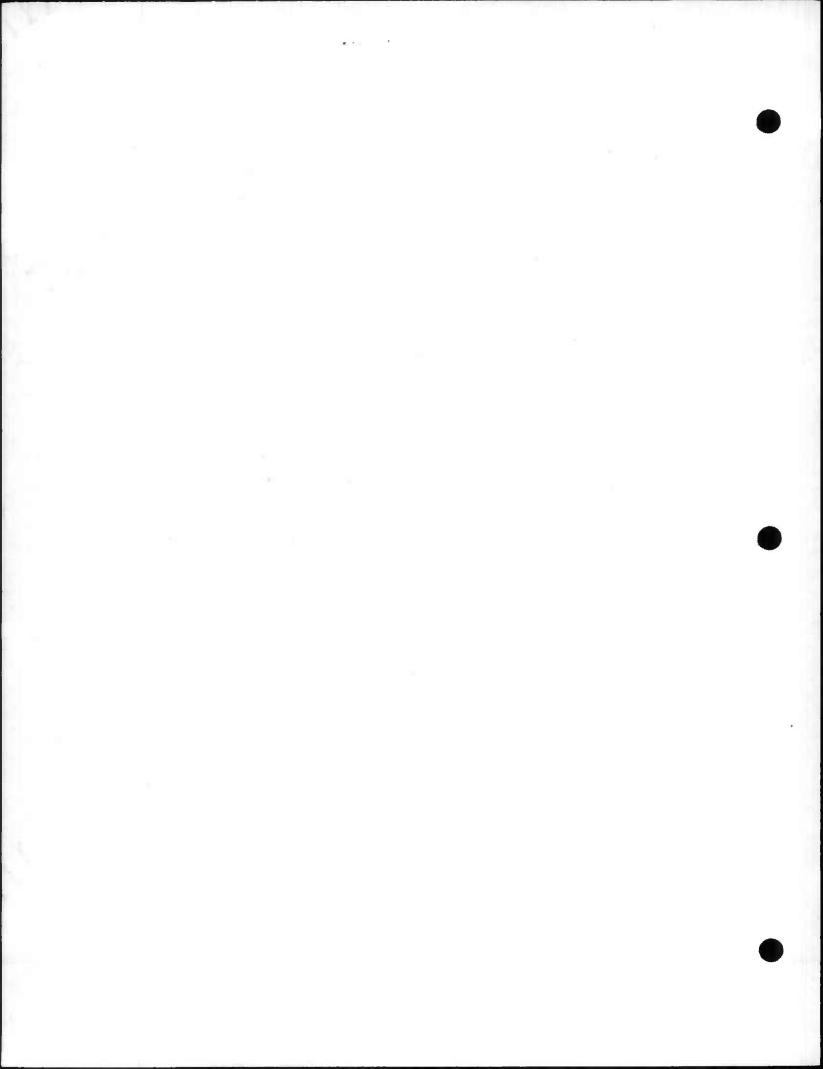
	nding physician.	is are contained formal, rayes 1, 2, 3 should		
Months office double Dance & man by additional to the first the second to the second t	124 Hours after death. Fage o may be retained by the hospital or att. V filled in by the funeral director page 5 should be detached for use	tion, or removal.	the medical examiner must be notified at once.	
STENDING DEVOICIBING The few requires that the death cadifornia he assessed with	TO THE NOVERTHAL OF ALL MONTHS OF THE CONTROLL OF DESCRIPTION OF THE AND THE MOST OF THE M	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal,	MPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL	TO THE FUNERAL D	be filed within 72 h	IMPORTANT: If It	

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTM ERTIFICA	ENT OF H	EALTH AND I	MENTAL HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last) Nellie W:	iggington				2. DATE OF DEATH MONTH 30 M	1995 YEAR	3. TIME OF DEATH 9:08P M		
		5. SEX 8. AGE (In yrs. In 1 M 2 X) F 9 4		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) APTIL 26	.01 Vi	HPLACE (State-or Foreign tryLeesburg rginia		
TOR	98. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital Silver Spring Montgom RESIDENCE OF DECEDENT									
DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION '							10d. INSIDE CITY LIMITS? 1 1 YES 2 NO		
ERAL	100. STREET AND NUMBER 12020 Centerhi	ll Street		0170	20902		10g. CITIZEN OF			
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S.AI FORCES? 1 YES 2 IF YES, OIVE WAR OR DATES	RMED NO	13. WAS DEC	cify Cuban, Maxicar	IC ORIGIN? (Specify Yes n, Puerto Rican, etc.)		E — American Indian, k, While, etc.		
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementery/Secondary (0-12) 5 th	ompleted) (G	ECEDENT'S USU. Give kind of work of DONOT use reti	done during mos red.)	N at of working	16b. KIND OF BUS	SINESS/INDUSTRY			
NO.	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAM	ME (First, Middle, Maiden	Surneme)			
BE (Unknown					Louveni		ond		
5	19a. INFORMANT'S NAME (Type/Print) Margaret Duva					St. Whea		20902		
	Margaret Duvall 12020 Centerhill St. Wheaton, MD. 20902 20s. METHOD OF DISPOSITION 1 Burlis 2 Cremetion 3 Removal from State 4 Donation 8 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Cagnetory, cremetory or other place) Georgetovin Med. Sch. 5/30/95 Washington, DC.									
	21. SIGNATURE OF SUNERAL SERVICE LICE			22. NAME AN	D ADDRESS OF FAC	HLITY				
	Jeny 4.	Claster		3605	14th S	ter Fune	Wash, Do			
	23.(PART I. Enter the diseases, or co ahock, or feart failure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death)	Terminal G	all B				ratory arrest,	Approximate Interval Between Onset and Death		
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
	PART II. Other algnificant conditions	contributing to death but not r	resulting in th	e underlying	cause given in F	Part I. 24a. WAS AN A		. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO		
ED	1. Atrial Fibr Failure 3.	Hypertension	Conges	tive	Heart	1 YES 2	□X•0	COMPLETION OF CAUSE OF DEATH?		
Z ≥	DID TOBACCO USE CONTRI			J NO X	UNCERTAIN			1 Tes 2 No N/A		
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		CE OF DEATH (C							
IXSI	1 X YES 2 □ NO	1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA 4	Nursing Home	5 Residence					
BY PHYSICIAN: MEDICAL	1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	286. TIME OF INJURY	28c, INJU WOF M 1 Y	RY AT RK? ES 2 NO	28d. DEŞCRIBE HOW IN	IJURY OCCURED			
	2 Accident investigation 3 Suicide 8 Could not be determined	28s. PLACE OF INJURY — At he building, etc. (Specify)	factory, offica		281. LOCATION (Street & City or Town, State)	nd Number or Rural I	Route Number,			
COMPLETED	29a. CERTIFIER (Check only one) 2 PHYSICA EXAMINER:	AN: To the best of my knowledge, de	eath occurred at investigation, in	the time, date a	and place, and due to	to the cause(a) and man	ner as stated.	s) end manner as stated.		
HA I	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMI D 2 8 6 5 6	BER	29d. DATE SIGNED May 3	(Month, Day, Year)		
2	Ravi Passi M	completed cause of death (ITER D. 8609 Secol	M 27) (Type, Print)	, #40	4 B,Si]	Lver Spri				
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGNATURE			***					



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DIVISION OF VITAL RECORDS, P.O. BOX 68760	Č
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		1 - FOR STATE REGISTRAR	STATE OF MARYLAI	ND / DEPART	MENT OF H	EALTH AND ME	NTAL HYGIEN	E	
		1. DECEDENT'S NAME (First, Middle, Last)					DATE OF DEATH DA		3. TIME OF DEATH
		THOMAS	WILSO	ONNC		-	JUNE 23		
		4. SOCIAL SECURITY NUMBER	10000000		IF UNDER 1 YEAR	IF UNDER 24 HRS, 7.	DATE OF BIRTH (Month, Day, Year)	8. B	BIRTHPLACE (State or Foreign Country)
29		220-34-4945	1 G M 2 🗆 F	80 YRS.			Sept 15.		Maryland
3 should	œ	9a. FACILITY NAME (If not institution, give st Prince George I				PRICE LOCATION OF DEATH	н	9c. COUNTY	
23	СТОВ	RESIDENCE OF DECEDENT	TOSPICAL CE.	ncer	Cire	verry		Prin	ce George
Pages 1,	DIREC	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	TION			10d. INSIDE CITY LIMITS?
permit. P	1	Maryland Pr	ince George	18	Chever				1 TES 2 ND
# per	FUNERAL	100. STREET AND NUMBER 8009 Sheriff	bsos		101	20785			OF WHAT COUNTRY?
physician. burlal-transit	N N	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U	I S ADMED	12 WE DEC	ENDENT OF HISPANIC	001011010101011		ed States
physic burial		1 Never Married 2 Married	FORCES? 1 X YES	2 NO	If yes, spe	ecify Cuban, Mexican, F			RACE — American Indian, Black, Whita, atc.
5-0020 ending physic as the burial) BY	3 Widowed 4 Divorced	WW II		1 🗌 YES	ND Specify:			Specify: White
r atte	ETED	15. DECEDENT'S EDUC (Specify only highest grade	:ATION completed)	(Give kind of wo	rk done during mo.	ON st of working	166. KIND OF BUS	INESS/INDUST	RY
of de la	2	Elementary/Secondary (0-12)	College (1-4 or 5+)	Farmer	,		Far	ming	
LAND 21215-U020 the hospital or attending physician detached for use as the burial-trai	COMPL	1.7. FATHER'S NAME (First, Middle, Last)		rarmer		16. MOTHER'S NAME			
# & & &	BE C	Joseph P. Wilso	on				rgia C.		S
retained by 5 should b notified a	0	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street a	nd Number or Rural Rout	e Number, City or Town	n, State, Zip Code	(e)
(f)	-	Frances Wilson				ff Road,			
		20a. METHOD OF DISPOSITION 5 Durial 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)					277, 1 29550	CATION — City of	or Town, State
direc direc		4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC	100	aryland	Veter	cans Cem			enham, Md
BALLIMOR ter death. Page 6 m the funeral director, wal. il examiner mus		► 0 D. 1	Y Bin	,	C C 2 2	Oll al	" Lee Fu	neral	Home, Inc
SAL I rs after death. n by the funera removal. sdical examil		23 PART I Enter the diseases or o	20 Velar	yer					Rd, Clinton
			List only one ceuse on each	ne death. Do no h line.	t enter the mo	de of dying, such a	a cardiac or respi	ratory arrest,	Interval Between
within 24 h pletely fille cremation, rent, the		IMMEDIATE CAUSE (Final disease or condition	Dicces	tion	a f	Aorha	Angila	1 160	Onset and Deeth
ted within 24 hours completely filled in ial, cremation, or re event, the med		reaulting in death)	DUE TO (OR AS A C	ONSEDUENCE OF):		110111	MEON	73001	day
executed with and complet to burial, crer matic event	N	Sequentially list conditions,							
be be	RTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CO	ONSEDUENCE OF):					
ertificate ing physical physic	FIC	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A C	ONSEQUENCE DF):					
. o bt =	H	resulting in death) LAST							į į
	CE	PART II Other eignificent condition	a contribution to do the but						
	CAL	PART II. Other significant conditions	lascular D			cause given in Pai	t I. 24a. WAS AN A		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
L RECOR	EDIC	CCICDIO	70(3(0)	13 00131			1 YES 2	No	OF DEATH?
r requ	Σ	DID TOBACCO USE CONTR	RIBUTE TO CAUSE OF	DEATH YES		UNCERTAIN			1 TES 2 NO
1 9 E C	SICIAN:	25. WAS CASE REFERRED TO MEDICAL	26.	PLACE DF DEATH		OTTOLKIANT			
SICIAN: The certificate he state he state he or item	SIC	EXAMINER? 1 YES 2 TO NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatk		OTHER:	e 5 Rasidence 6	Other (Specify)		
PHYSICIAN: this certifical with the Str	РНУ	27. MANNER OF DEATH 1 Natural 5 Pending	2Sa. OATE DF INJURY (Month, Day, Year)	28b. TIME (OF 28c, INJU	URY AT 25 RK?	d. OEȘCRIBE HOW IN	JURY OCCURE	0
DING PHYS After this death with	BY	2 Accident Investigation	OR - DI ACE OF IN HIOV	441		ES 2 ND			
TTEN TOR: after	딢	3 Suicida S Could not be 4 Homicide determined	26a. PLACE OF INJURY — building, etc. (Specify))	eat, tactory, office	26	t. LOCATION (Street a: City or Town, State)	nd Number or Au	Iral Route Number,
OR A DIRECT HOURS	LET	29a. CERTIFIER 1 TO FERTIFYING PHYSIC	CIAN: To the best of my knowled	los desth secured					
HOSPITAL FUNERAL WITHIN 72 I	COMPL		R: Dn the beals of examination a						use(a) and manner as stated.
THE HOSPI THE FUNEF filed within		29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBE			NED (Month, Day, Year)
TO THE HOSPITAL TO THE FUNERAL be filed within 72 IMPORTANT: If) BE	Aloy (. Lx	Jan. gr.)	-	0395	10	▶ 6 /	124/90
	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	H (ITEM 27) (Type, P	rint)	n F /	01.1	1	10 /
		George C Ha			4850	o rorbe	· ISIUd.	Lukko	m. Hd 20706
		31. DATE FILEO (Month, Dey, Year)	32. REGISTRAR'S SIGNATI	URE					

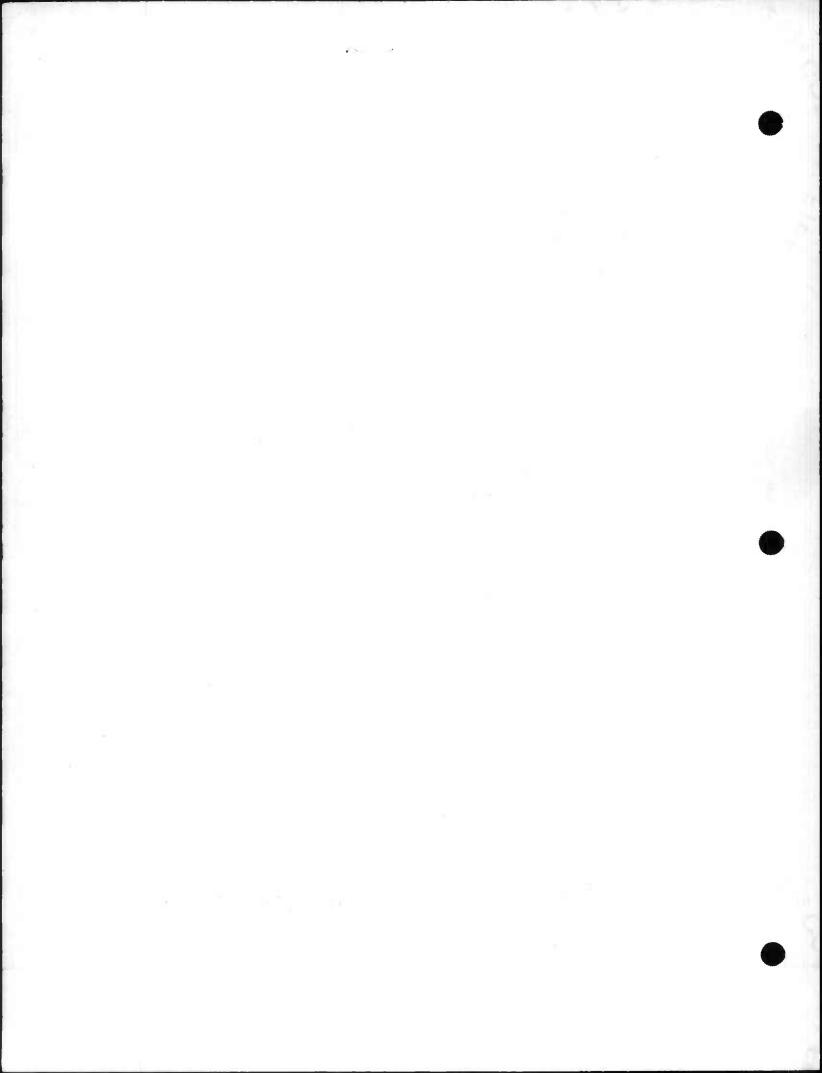


the hospital or attending physician. detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	MIAL	RAL	27
	HOSE	FUNE	within
	出	포	pied
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be c	be filed within 72 hours after death with the State Dept. or Health and Mental Hygiene prior to burial, cremation, or removal.

	1 - STATE REGISTRAR	STATE OF MARYLAN	ND / DEPARTMENT CERTIFICATE	OF HEALTH AND	MENTAL HYGIEI						
	1. DECEDENT'S NAME (First, Middle, Las	1)			2. DATE OF DEATH		3. TIME OF DEATH				
	INA	WELLS					95 11:20 AM				
	4. SOCIAL SECURITY HUMBER		yrs. last birthday) IF UNDER		7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)				
	579-38-9713	1 M 2 X F 62	VRS	DAYS HOURS MIN.	Sept 13	1 1 9 3	2 Wash DC				
l ~	9e. FACILITY NAME (If not institution, give	Y OF DEATH									
DIRECTOR	Prince George	nce George									
E		106. STATE 106. COUNTY 106. CITY, TOWN OR LOCATION Hillside									
	100. STREET AND NUMBER										
IERAL	1010 Kayak A	ve	101. ZIP CODE 2074				n of what country? ed States				
FUNI	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U FORCES? 1 YES	I.S. ARMED 13. V	AS DECENDENT OF HISP	AHIC ORIGIN? (Specify Vi	s or No— 1	t. RACE — American Indian,				
BY B	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATE		yes, specify Cuban, Mexi-			Black, White, etc. Specify:				
							White				
E	15. DECEDENT'S EC (Specify only highest gra		6a. DECEDENT'S USUAL OC (Give kind of work done d	CUPATION uring most of working	16b. KIND OF BI	ISINESS/IHDUS	STRY				
٦	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use retired.)								
once.	11 th 17. FATHER'S NAME (First, Middle, Last)		Homemake	7	Home						
2 0		ey Douglas			NAME (First, Middle, Melder ys Tawney						
TO BE COM	19e. IHFORMANT'S HAME (Type/Print)		10h MAII INC ADDRESS								
일				(Street and Number or Rurs							
8	Ina Shepherd	20h PI	LACE AND DATE OF DISPOSE	untry La	ne. Waldo		[d 2060] y or Town, State				
unst	1 Buriel 2 Cremetion 3 Re 4 Donation 5 Other (Specify)		LACE AND DATE OF DISPOSI ery, crematory or other place)		7,1995 Su						
ě	4 Donation 5 Other (Specify) Cedar Hill Cemetery Suitland, Md 21. SIGNATURE OF FUHERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY LEE FUNETAL HOME, Inc. 65										
E	► 00 n	PRID									
-	Old Alexander Ferry Rd, Clinton, Md 2										
Injury, or other traumatic event, the medical examiner must	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate interval Batween										
å .	immediate cause (Final disease or condition resulting in death) SEPSIS, HYPOTENSION, RESPIRATORY AND RENAL FAILURE DYS.										
vent	Tooditing in death)										
a Z	MYOCARDIAL INFARCT 5-6 W										
E D	Sequentially list conditions, oue to (or as a consequence of):										
를 를	CAUSE (Disease or injury		E RENAL INFA		10 DYS.						
制造	that initiated events resulting in death) LAST	DUE TO (OR AS A CO	ONSEQUENCE OF):								
y, or other traumatic CERTIFICATION	d										
AL AL	PART ii. Other significant condition	ons contributing to death but	not resulting in the unc	leriying cause givan i	n Part I. 24a. WAS AI		24b. WERE AUTOPSY FINDINGS				
					PERFO		AMAILABLE PRIOR TO COMPLETION OF CAUSE				
shows any							OF DEATH?				
S 2	DID TOBACCO USE CON	TRIBUTE TO CAUSE OF	DEATH YES IN	O UNCERTA	IN 🗆		71.20.20.10				
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		PLACE OF DEATH (Check o	nly one)							
or Item 23 YSICIAN	1 VES 2 THO	HOSPITAL:	ent 3 DOA 4 Nursi	ng Home 5 - Residence	6 Other (Specify)						
취	27. MAHHER OF BEATH	28e. OATE OF IHJURY (Month, Day, Year)		Rec. IHJURY AT	28d. OESCRIBE HOW	IHJURY OCCU	RED				
marked, BY PH	1 Netural 5 Pending 2 Accident Investigation		M	WORK?							
= 0	3 Suicide s Could not be	26a PLACE OF INJURY	At home, ferm, street, fecto	ry, office	261. LOCATION (Street	and Number or	Rural Route Number,				
m 28 is ETED	4 Homicide determined		Y		City or Town, State	,					
필급	29e. CERTIFIER 1 CERTIFYING PHY	SICIAH: To the best of my knowled	ge, death occurred at the tin	ne, data and place, and du	re to the cause(s) and ma	nner es stated					
ANT: If ite		HER: On the basis of examination as					suse(s) end manner as stated.				
E C	296. SIGNATURE, AHO TITLE OF CERTIF			29c, LICEHSE NI			IGNED (Month, Day, Year)				
2 0	Muluh			D4360		► Co	125/6-				
- 0	11-1-1-1-1										
일	30. HAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) PRINCE GEORGES HOSPITAL CENTER										
- 2	WILLIAM J. BOYCE	M.D.	PI								
- 4	30. HAME AND ADDRESS OF PERSON WILLIAM J. BOYCE 31. DATE FILED (Month, Dev. Year) JUN 2 8 1991	E, M.D.	71	RINCE GEORG 101 HOSPITA							

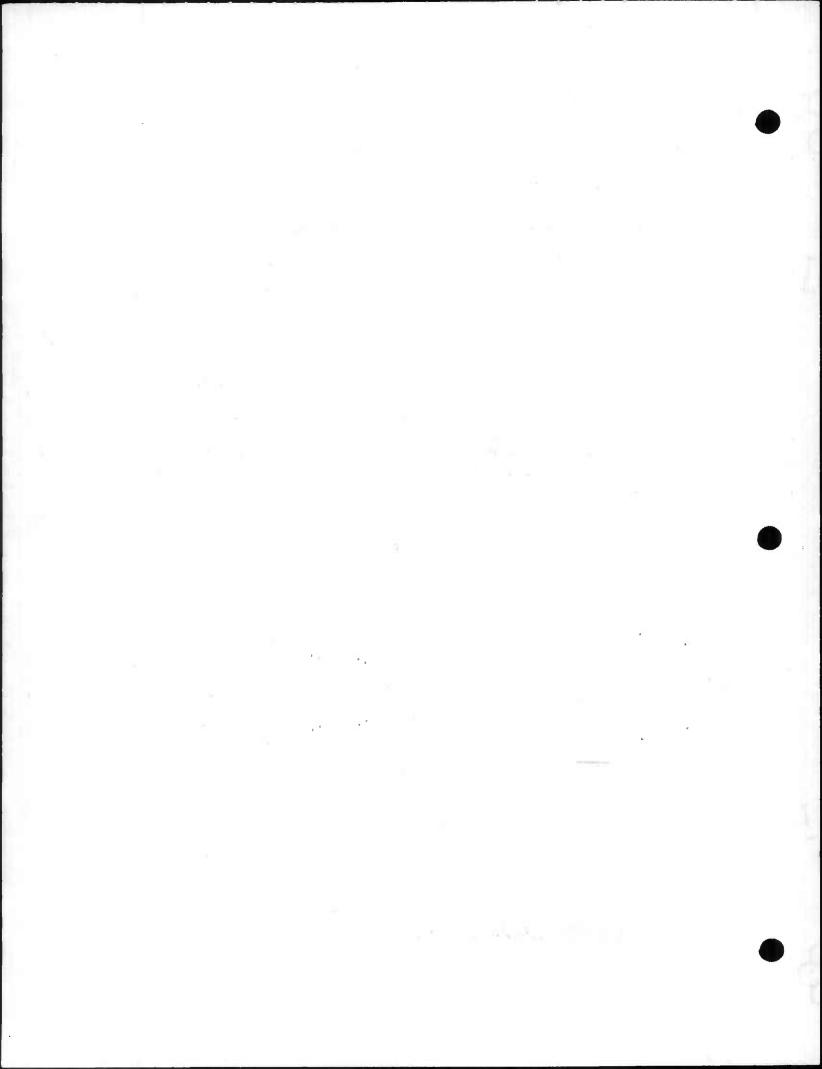


ITEMS: 23 PART I, 27, PER MEO FILM G-725 7/24/95 t.t

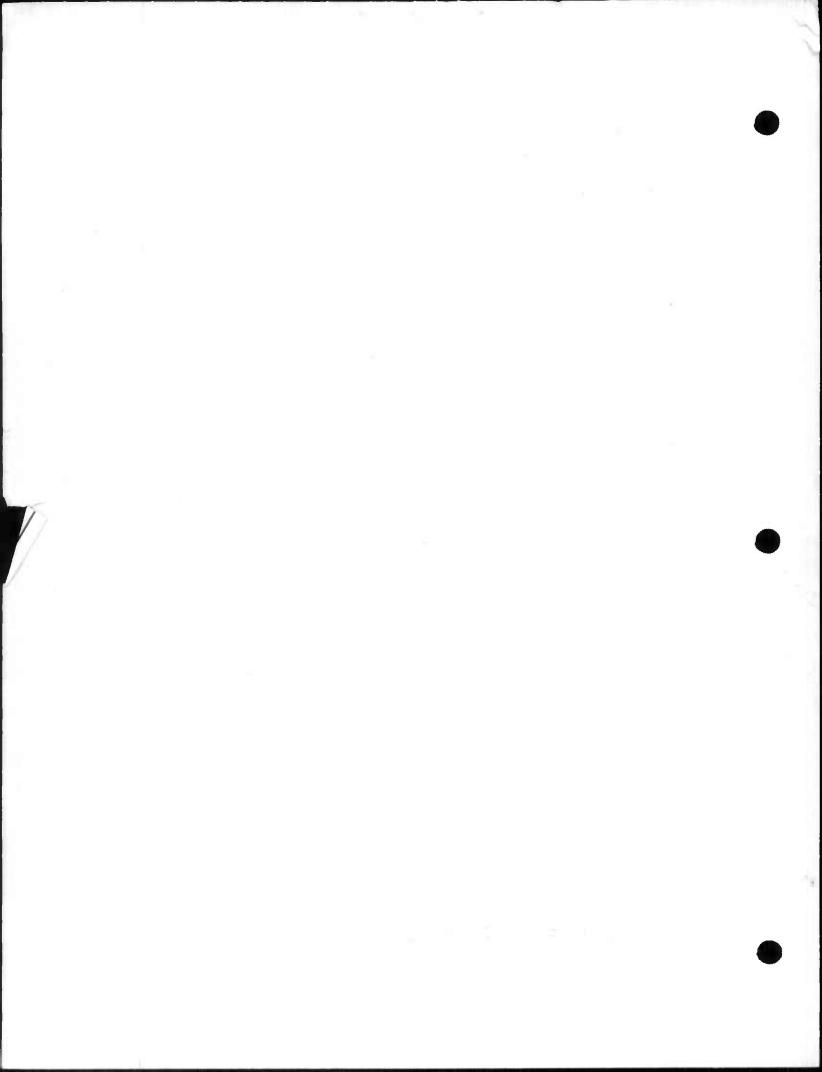
DIVISION OF VITAL RECORDS. P.O. BOX 68760

FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
REGISTRAR	CERTIFICATE OF DEATH	BEG NO

	REGISTRAR		CERTIF	ICATE (OF DEATH	REG. NO	O	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH	DAY VE	3. TIME OF DEATH
	Amanda	Nicol		Wi	Ley	June 28	1995	1625 M
	4. SOCIAL SECURITY NUMBER 219-41-0968		(In yrs. lest birthday)	MONTHS DA	and the second second	7. DATE OF BIRTH (Month, Day, Year)	6. 1	BIRTHPLACE (State or Foreign Country)
		1 M 2 K F 1	YRS.			June 26,		Maryland
or	9a. FACILITY NAME (If not institution, give s	treet and number)		9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH				
DIRECTOR	206 Pangborn Blvd. Hagerstown Washington							
RE	10a. STATE 10b. COUNT		10c. CI1	Y, TOWN OR L				10d. INSIDE CITY LIMITS?
		ngton		Su	ithsburg			1 XYES 2 NO
FUNERAL	100. STREET AND NUMBER 22100 Pikeside Dr	ive			101. ZIP CODE 21783		12	OF WHAT COUNTRY?
5	11. MARITAL STATUS	12. WAS DECEDENT EVER		13. WAS	DECENDENT OF HISPA	NIC ORIGIN? (Specify Ye	es or No.— 14.	RACE — American Indian,
B	1 X Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 Tyes			i, specify Cuban, Maxic YES 2 X NO Speci			Black, White, atc. Specify: White
ETED	15. DECEDENT'S EDU (Specify only highest grade	CATION COMPRISED	16a. DECEDENT'S	USUAL OCCU	PATION	16b. KIND OF BU	JSINESS/INDUST	RY
<u>-</u>	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	se retired.)	g most of working			
를	0	0						
COMPL	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maide		
BE	Jessie Lee Wiley				Tina A	Arleen Sou	ders	
6	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or To		
-	Tina A. Souders W	iley	22100	Pikes	ide Dr., S	Smithsburg	, Maryl	and 21783
	20a. METHOD OF DISPOSITION 1XC Burlel 2 Cremation 3 Ram	oval from State	b. PLACE AND DATE	OF DISPOSITIO	\(Name of	DATE 20c. L	OCATION — City	or Town, State
	4 🗆 Donation 5 🗆 Other (Specify)	C	edar Lawi	n Memoi	ial Park	7-1-95 B	lagersto	own, Maryland
	21. SIONATURE OF FUNERAL SERVICE LIC	ENSEE	/		E AND ADDRESS OF FA	CILITY		
	> 20001	Mmunn	11		NICH FUNER			27.1
	23. PART I. Enter the diseeses, or	complications that cause	d the deeth. Do	not enter the	mode of dylan aug	BIVG., Hag	erstown	, Md. 21740
	anock, or neart failure.	List only one cause on o	eech line.		mode of dying, add	in all column of rest	matory arreat,	Interval Between
- 1	IMMEDIATE CAUSE (Final disease or condition	SUDDEN INFA	NT DCATH C	MDDOME				Onset and Death
ł	resulting in death)		A CONSEQUENCE O					
-				. ,.				i
ੁ	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE O	F):				
8	cause. Enter UNDERLYING							İ
Ē	CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS	A CONSEQUENCE O	F):				+
CERTIFICATION	resulting in death) LAST	d.						
	DARK II ON a startful of the							
EDICAL	PART II. Other significent condition	a contributing to deeth i	but not resulting	In the underl	ying cause given in	Pert I. 24a. WAS AP PERFO		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
ĭ						1 VES	2 🗆 NO	COMPLETION OF CAUSE OF DEATH?
								1 YES 2 NO
ÿ.	DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	OF DEATH YE	S NO	□ UNCERTAIL	N 🗆		
5	,25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT					
Z	YES' 2 NO	1 Inpatient 2 ER/Out	petient 3 🗆 DOA	OTHER:	fome 5 🗆 Rasidenca	8 Nother (Specify) d	aycare	ecenter
Y PHYSICIAN: M	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	URY	INJURY AT WORK?	26d. DESCRIBE HOW		
9	2 Accident Investigation 3 Suicide 6 Could not ba	26f. LOCATION (Street		ural Route Number,				
	4 Hornicide determined	building, atc. (Spe	спу)			City or Town, State)	2161
ן ב	29a. CERTIFIER (Check only	CIAN: To the best of my know	viedos, dasth occurr	ed at the time	fete and place, and due	to the sever(s) and ma		
COMPLET	one) 2 MEDICAL EXAMINE	R: On the basis of examination	on and/or investigation	n, in my opinio	n, death occured at the	time data and place as	nd due to the car	(so(s) and manner to stated
	296. SIGNATURE AND TITLE OF CHRYSFIER	*						
# H	May - In	16.00	6 100		29c. LICENSE NUI			NED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CATTER	WV)		O.C.M	.E.	June	29 1995
	Margarita Kore	II M.D.	111 P∈	enn St	reet, Ba	ltimore,	Mary]	land 21201
	JUL 1 0 1995	12, HEOISTRAR'S SIGN	And II					
	COLT 0 1000	The many	-					



									1 1	.014	
	1 - STATE REGISTRAR	STATE OF MAR	RYLAND / DEI CERT	PARTMENT FIFICATE	OF HEALTH AND	MENTA	AL HYGIEN REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	E OF DEATH	ly.	YEAR	3. TIME OF DE	ATH
	GLENN D.	ZIMMERM				June		1995		11:30	А. м
	214-10-1817	1 M 2 🗆 F	92 YF		YEAR IF UNDER 24 HRS DAYS HOURS MIN.	(Mont	OF BIRTH th, Day, Year) L.24,19	02	Country	yland	Foreign
œ	9a. FACILITY NAME (If not institution, give str				TOWN OR LOCATION OF	OEATH			NTY OF DE		
Ē	Meridian Nursin	g Center		Fre	derick			Fred	ericl	k	
DIRECTOR	10a. STATE 10b. COUNTY		10c	. CITY, TOWN OF	LOCATION				T	10d. INSIDE CIT	Υ
	Maryland	Frederick		Walk	cersville					LIMITS?	NO NO
M	10a. STREET AND NUMBER				10f. ZIP CODE			10g. CITI	ZEN OF W	HAT COUNTRY?	
Ä	54 Maple				2179	93		Uni	ted S	States	
FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVE FORCES? 1 \(\subseteq \text{Y}	ER IN U.S. ARMED	13. W	AS DECENDENT OF HISF yes, specify Cuban, Max	ANIC ORIGI	N? (Specify Yea	or No-	14. RACE Black.	- American Ind White, etc.	llan,
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR O	R DATES		YES 2 NO Spe				Specify	White	
0	15. DECEDENT'S EDUC	ATION	16a. DECEDE	NT'S USUAL OCC	CUPATION	168	b. KIND OF BUS	INESS/IND	_		
ET	(Specify only highest grade of Elementary/Secondary (0-12)	Cottege (1-4 or 5+)	(Give kin life. Do N	od of work done du IOT use retired.)	ring most of working						
MPL	9th	_	Lab I	echnici	an	Į	J.S. Go	vern	ment		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S	NAME (First,	Middle, Maiden	Sumame)			
BE		ORSEY ZI	MMERMAN		SUSA				MITH		
5	19a. INFORMANT'S NAME (Type/Print)	N TD			Street and Number or Run					201	
	GLENN D. ZIMMERMAN		20b. PLACE AND D	-	iteaugay /		timore,			234	
	1 Burial 2 Cremation 3 Remote 4 Donation 5 Other (Specify)	val from State	St. Luk	y or ether place)	ot ory	6-2				m, Stata Maryla	nd
	21. SIGNATURE OF FUNERAL SERVICE LICE		DE. Duk		AME AND ADDRESS OF	EACH ITY					IIG
	NO h	101					Stauffe				_
	23. PART I. Enter the diseases, or co	omplications that cau	used the deeth.	Do not enter t	Fulton Av	re./ W	walkers	VILL	e, Mo	1. 21/9	
	shock, or heart failure. L										
		ist only Dne ceuse D	n eech line.		in mode of dying, si	icii aa car	area or reapn	atory arr	wor,	Interval E	letween
	IMMEDIATE CAUSE (Finel	^	n eech line.							Interval E Onset an	etween d Death
	IMMEDIATE CAUSE (Finel	DUE TO (OR)	n eech line.							Interval E Onset an	letween
NC	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	DUE TO (OR)	AS A CONSEQUENCE	te cu						Interval E Onset an	etween d Death
ATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	DUE TO (OR)	n eech line.	te cu						Interval E Onset an	etween d Death
FICATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR A	AS A CONSEQUENCE	CE OF):						Interval E Onset an	etween d Death
RTIFICATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR A	AS A CONSEQUENCE	CE OF):						Interval E Onset an	etween d Death
CERTIFICATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR A	AS A CONSEQUENCE	CE OF):	th bo	ny r				Interval E Onset an	etween d Death
- 1	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that infiliated events	DUE TO (OR A	AS A CONSEQUENCE	CE OF):	th bo	ny r		AUTOPSY	24b.	MERE AUTOPSY F	d Death Control
- 1	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR A	AS A CONSEQUENCE	CE OF):	th bo	ny r	mtc	AUTOPSY MED?	24b.	Interval E Onset an 2 2 2 1	d Death Control
- 1	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other alignificent conditions	DUE TO (OR A OUE TO (OR A Contributing to deet	AS A CONSEQUENCE AS A CONSEQU	CE OF): CE OF): CE OF):	erlying ceuse given	n Part I.	24a. WAS AN PERFORI	AUTOPSY MED?	24b.	MERE AUTOPSY PAMILABLE PRIOR	Eletwoon d Death Carly Eletwoon d Death Carly Eletwoon d Death Carly Carl
- 1	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR A OUE TO (OR A Contributing to deet	AS A CONSEQUENCE AS A CONSEQU	CE OF): CE OF): VES \[\bigcup N \]	erlying ceuse given	n Part I.	24a. WAS AN PERFORI	AUTOPSY MED?	24b.	WERE AUTOPSY F AMAILABLE PRIOR OF DEATH?	Eletwoon d Death Carly Eletwoon d Death Carly Eletwoon d Death Carly Carl
- 1	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	DUE TO (OR A OUE TO (OR A Contributing to deet	AS A CONSEQUENCE AS A CONSEQU	CE OF): CE OF): CE OF): VES \[\] N DEATH (Check on OTHER):	erlying ceuse given i	n Part I.	24a. WAS AN. PERFORI 1 YES 2	AUTOPSY MED?	24b.	WERE AUTOPSY F AMAILABLE PRIOR OF DEATH?	Eletwoon d Death Carly Eletwoon d Death Carly Eletwoon d Death Carly Carl
- 1	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	DUE TO (OR A OUE TO (OR A CONTributing to deet BUTE TO CAUSE HOSPITAL: 1 Inpettent 2 ER/C	AS A CONSEQUENCE AS A CONSEQU	YES N DEATH (Check on OTHER) A OTHER TO THE OF 12	erlying ceuse given in the control of the ceuse given in the ceuse given given in the ceuse given in the ceuse given in the ceuse given	n Part I.	24a. WAS AN. PERFORI 1 YES 2	AUTOPSY MED?	24b.	WERE AUTOPSY F AMAILABLE PRIOR OF DEATH?	Eletwoon d Death Carly Eletwoon d Death Carly Eletwoon d Death Carly Carl
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BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be	DUE TO (OR A OUE TO (OR A OUE TO (OR A CONTributing to deet CONTRIBUTE TO CAUSE HOSPITAL: 1 Inpatient 2 ER/C 28a. OATE OF INJUI (Morth, Day, Yes	AS A CONSEQUENCE AS A CONSEQU	YES N DEATH (Check on Nursel' INJURY M	erlying ceuse given O. A UNCERTA Ny one) Ing Home 5 Rasidence Sc. INJURY AT WORK? 1 YES 2 NO	n Part I. IN 28d. DES	24a. WINS AN PERFORI 1 VES 2	AUTOPSY MED? PRO	24b.	WERE AUTOPSY F AMAILABLE PRIOR COMPLETION OF OF DEATH?	Eletwoon d Death Carly Eletwoon d Death Carly Eletwoon d Death Carly Carl
BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other algnificent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending investigation	DUE TO (OR A OUE TO (OR A CONTRIBUTING TO GET CONTRIBUTE TO CAUSE HOSPITAL: 1 Inperient 2 ER/C (Month, Dey, Yer	AS A CONSEQUENCE AS A CONSEQU	YES N DEATH (Check on Nursel' INJURY M	erlying ceuse given O. A UNCERTA Ny one) Ing Home 5 Rasidence Sc. INJURY AT WORK? 1 YES 2 NO	n Part I. IN 28d. DES	24a. WAS AN / PERFORI	AUTOPSY MED? PRO	24b.	WERE AUTOPSY F AMAILABLE PRIOR COMPLETION OF OF DEATH?	Eletwoon d Death Carly Eletwoon d Death Carly Eletwoon d Death Carly Carl
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FOR STATE REGISTRAR

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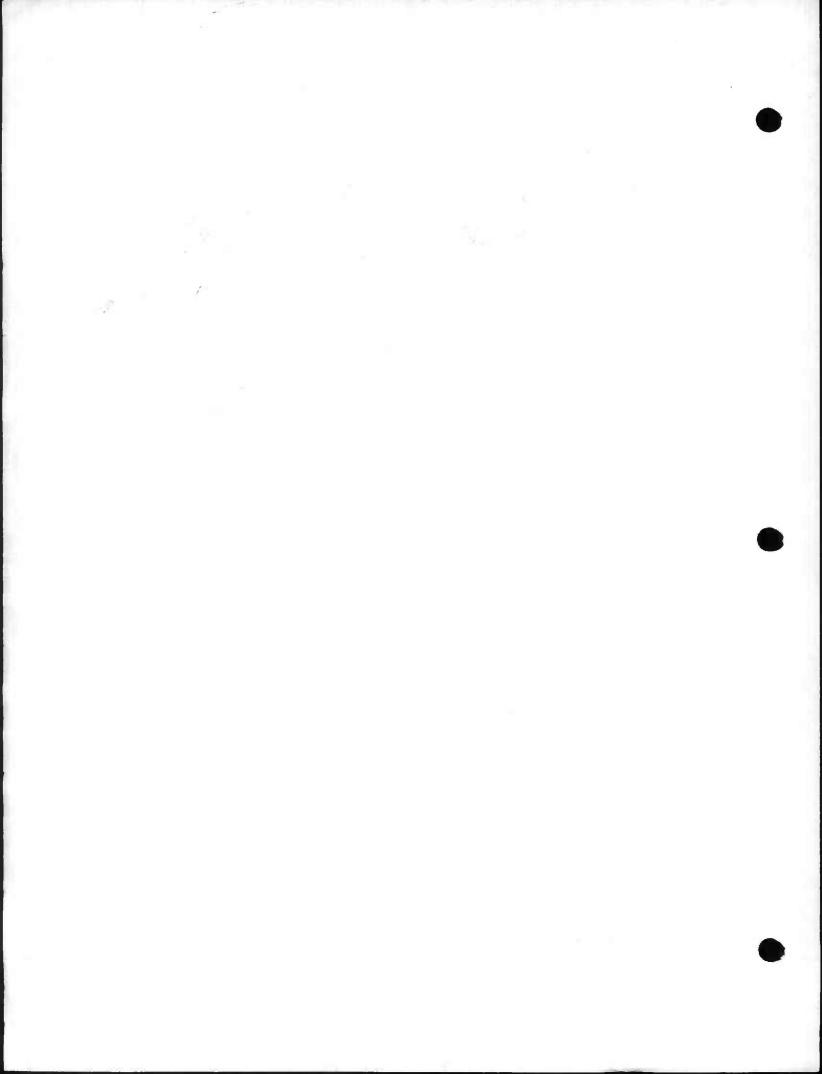
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should		9a. FACILITY NAME (If not institution, give street			9b. CITY, TOW	OR LOCATION	N OF DEAT	'n	9c. COUN	TY OF DEATH	
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use as	윤	ts. DECEDENT'S EDUCATI (Specify only highest grade con	ION noleted)	18a. DECEDENT'S	USUAL OCCUPA			16b. KIND OF B	USINESS/IND	ISTOV	
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s should notified	2	ton. INFORMANT'S NAME (Type/Print)					or Rural Rou	ite Number, City or To		-	
ay be re page 5	-	Josephine A	muso	1729	RIT	AR	OAL	BAL	10. V	nD o	21222
Page 6 may be retained il director, page 5 should ner must be notified		20a. METHOD OF DISPOSITION 1 Derial 2 Cremation 3 Removal		PLACE AND DATE		Name of		OATE 20c. L	OCATION — C	Sity or Town, S	tata
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death. Pag e funeral di l. examiner		21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE		22. NAME	AND ADDRESS	S OF FACIL	PPM			Dundalk
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the death certificate be yether attending physician or Mental Hygiene prior to Injury, or other traur	CE	PART ii. Other aignificant conditions of	ontribution to don't b	of mat acculated	to the condess.	Con a chairman					
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OR ATTENDING PHYSICIAN: The law DIRECTOR: After this certificate has b hours after death with the State Dept Nem 28 is marked, or item 23	8	3 Suicide 8 Could not be 4 Nomicide determined	= At nome, farm,	m, streel, factory, offica 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					łumber,		
. OR ATTENDING I DIRECTOR: After hours after death item 28 is mail	Щ										
1	MPL	29a. CERTIFIER (Check only one) One) (Check only one)									
HOSPITAL FUNERAL WITHIN 72 I	CO	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the ilms, data and place, and due to the cause(s) and manner as stated.									
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If	ш	296. SIGNATURE AND TITLE OF CERTIFIER	VV	\		29c. LICEN		-	29d. DATE	SIGNED (Mont	h. Day. Year)
TO THE De filed MPOR	TO B	Jahur Was	01-4 - M	/		100	4021	8	D 7	17/1	3
~	F	30. NAME AND ADDRESS OF PERSON WHO CO		ATH (ITEM 27) (Type	Print) (2 / 1	vet 61	R	Balt M	2	215 N	7
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



BALTIMORE, MARYLAND 21215-0020

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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 12:35 MCS SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. leat birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1X M 2 - F 218-03-4223 77 YRS. Nov 11, 1917 Maryland 9a. FACILITY NAME (If not int 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR Memor N/A DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland N/A Baltimore 1 F YES 2 NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3716 Elm Avenue 21211 U.S.A. 11. MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMEO FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES XX NO Specify: 1 Never Married 2 Marr 3 Widowed 4 Divorced BY Specify: White WWII COMPLETED 15. OECEOENT'S EOUCATION (Specify only highest grade complete 16a. OECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 11 Industrial Meter Reader Baltimore City Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) BE James Addis Henrietta Ruhmann 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stets, Zip Code) 2 Grace Addis 3716 Elm Avenue 20a. METHOD OF DISPOSITION
1 X Burlel 2 Cremetion 3 Removal from State
4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Dulaney Valley Memorial Gdns 7/10/95 Timonium Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue Baltimore, Maryland 212 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between IMMEDIATE CAUSE (Final Onset and Death disease or condition SEPS15 24 hours resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sipmoid perforation 4 hours CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF) resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY 246. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Diabetes h tension hronic 1005 1 TYES 2 NO rena 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Inpetient 2 ER/Outpetient 3 DOA OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNEB-OF OEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 5 Pending Investigation 1 Natural 1 YES 2 NO COMPLETED BY 2 Accident 28s. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide determined 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF DERFIE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) M.D.

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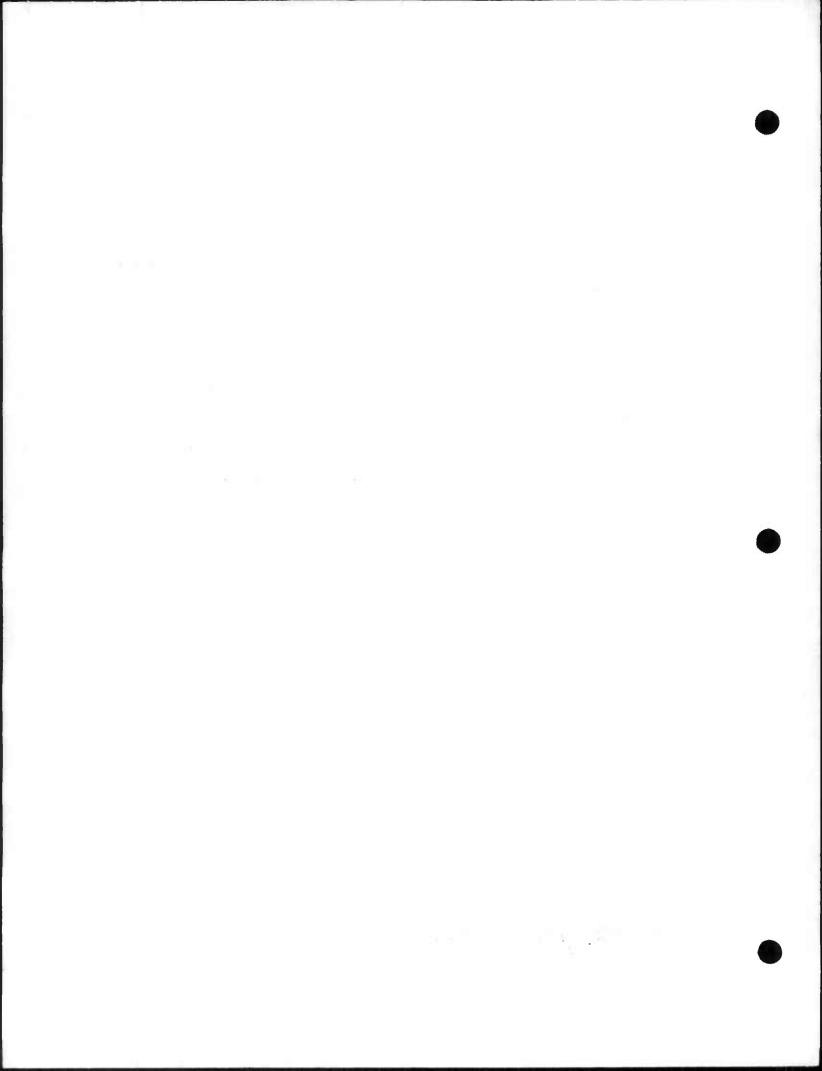
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Tunchilek M.D. 32. REGISTRAR'S SIGNATURE

RESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit		
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95 20751 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH BRYANT ROBERT 3:40 P. 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country) 218-48-3844 % M 2 □ F DAYS HOURS MIN. 03-26-48 47 S.C. 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH UNVERSITY HOSPITAL DIRECTOR BALTIMORE N/A RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD. N/A BALTIMORE 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 812 N. MOUNT STREET 21217 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuben, Mexican, Puerto Rican, etc.)

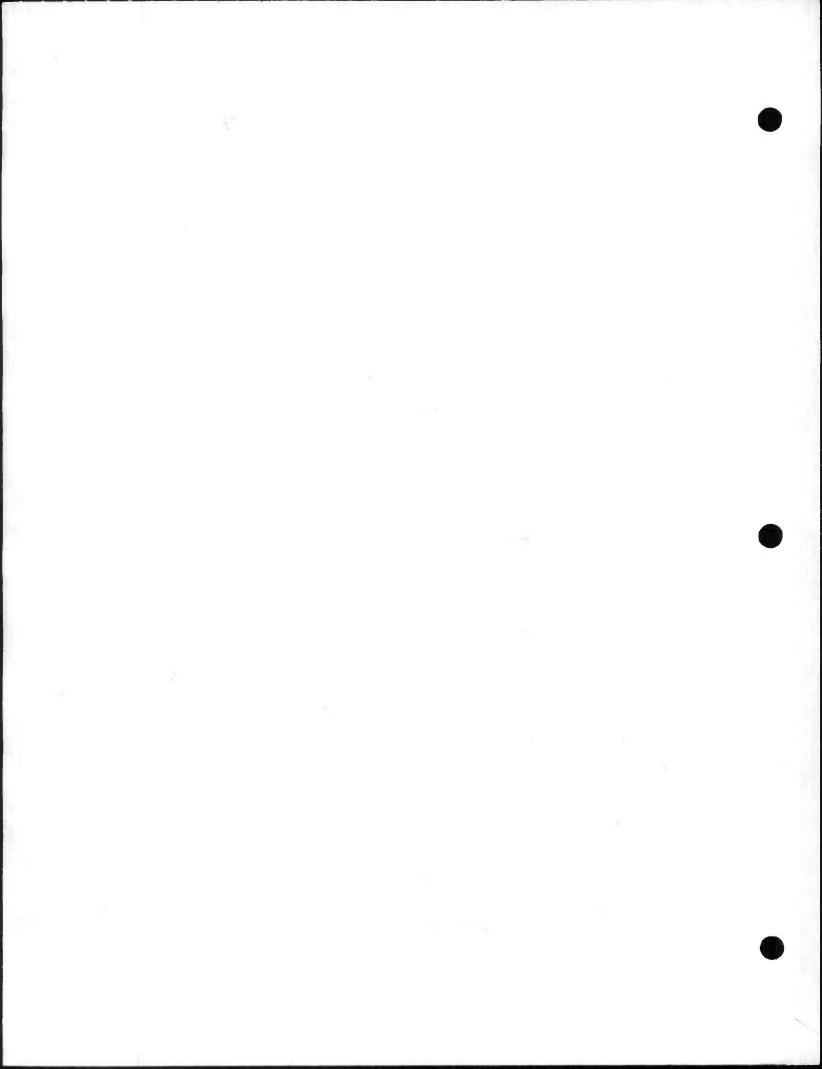
1 YES 2 NO Specify: IF YES, GIVE WAR OR DATES ΒY 3 Widowed 4 Divorced BLACK COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ost of working (Give kind of work done life, Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) 7th CONSTRUCTION UNK notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) ERNESTEEN R. HOLMES CORA E. LEE BE 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 CORA LEE HOLMES BALTO. MD. 21217 812 N.MOUNT STREET 2 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must N Buriel 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) ery, cremetory or other place)
ZION CEMETERY 07-14-95 LANSDOWNE, MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSES examiner 22. NAME AND ADDRESS OF FACILITY ALBERT P. WYLIE F/H PA 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, medical Approximats interval Between **IMMEDIATE CAUSE (Final** Onset and Death the disease or condition RENAL PAILURE Days reaulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? ашу 1 TYES 2 NO 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO 🕱 UNCERTAIN 🗆 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem OTHER:
4 | Nursing Home 5 | Residence 8 | Other (Specify) 1 TYES 2 NO 1 % Inpetiant 2 - ER/Outpatient 3 - DOA 0 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked 1 Natural
2 Accident 5 Pending 1 YES 2 NO BY Investigation 3 Suicide 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 Is a Could not be COMPLETED 4 Homicide 29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL C TO THE FUNERAL D be filed within 72 ho IMPORTANT: If Its 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Q2 W. HILL ST BALTIMORE, MD

CURTIN, M.D.

July 30 150 THE FOUND



BALTIMORE, MARYLAND 21215-0020	4 hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should this State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	e medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

MAKEEB

JOHNS

32 REGISTRAR'S GONATURE

HOLKINS

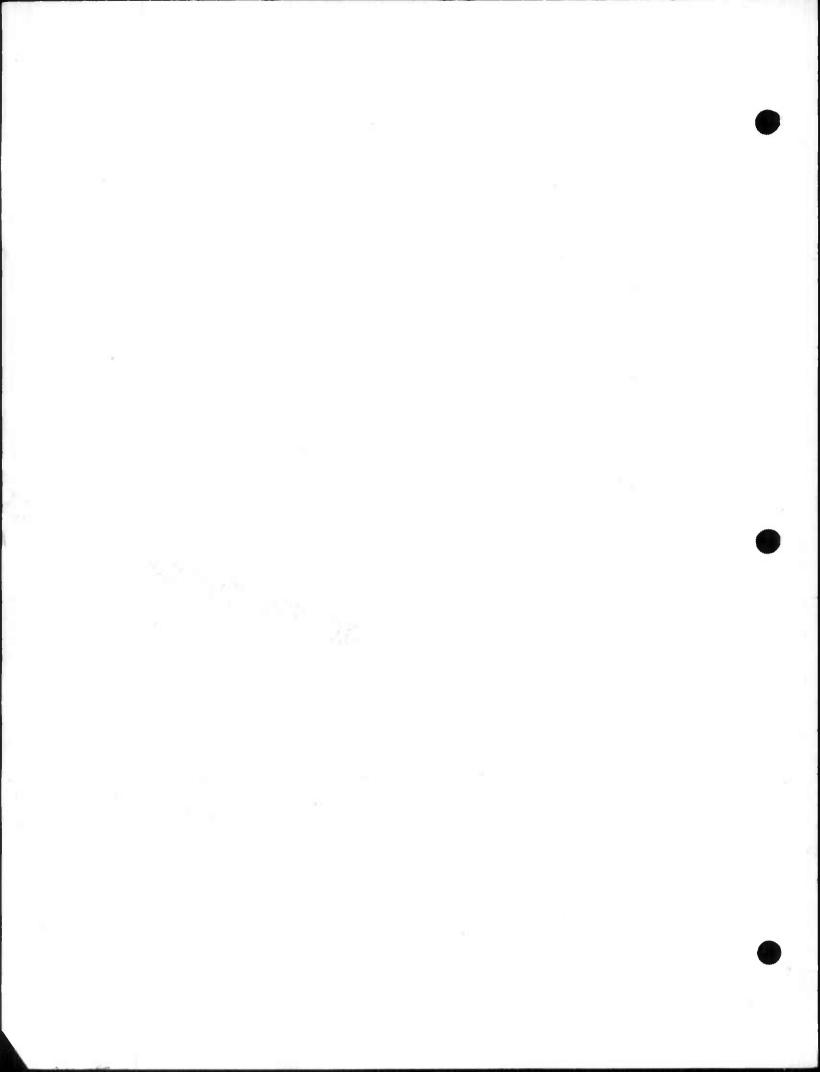
ATTILA

31. DATE FILED (Month, Day, Year)

JUL 1 0 1995

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Lest)		- 01		CATE	PEATH	2. DATE OF DEATH		_	3, TIME OF DEATH	_
	DARIAN	KEITH		12.	ROWN		JULY 8	DAY	YEAR		
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. les		IF UNDER 1 YEAR	R IF UNDER 24 HRS.	7 DATE OF BIRTH			1:56A PLACE (State or Foreign	M
	213-92-1758	1 5√M 2 □ F	25	YRS.	MONTHS DAY		(Month, Day, Year 02-07-	70	Countr	MD.	
	Se. FACILITY NAME (If not institution, give	street and number)			9b, CITY, TOW	N OR LOCATION OF			INTY OF D		_
8	THE JOHNS HO	PKINS HOST	PTTAT.			_					
5	RESIDENCE OF DECEDENT										
DIRECTOR	10s. STATE 10b. COUNT	TY		10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS?	
	MD . N/A				BALTIMORE					1X YES 2 □ NO	
R.	319 N. ELLWOO	10f. ZIP CODE 10g. CITIZEN OF WHAT									
FUNERAL	11. MARITAL STATUS	T				21224		USA			
	1 X Never Married 2 Married	12. WAS DECEDENT E	YES 2 X N	NO If yes, specify Cuban, Mexican, Puarto Rican, etc.) Blac					14. RACE Black	- American Indian, , White, etc.	
BY	3 Wildowed 4 Divorced	IF YES, GIVE WAR	OR DATES		1 🗆 Y	ES 2 XNO Spec	olfy:		Speci	BLACK	
0	15. DECEDENT'S ED	JCATION	16a. DE	CEDENT'S	USUAL OCCUPA	TION	16b. KIND OF	BUSINESS/IN	DUSTRY		_
H	(Specify only highest grad	College (1-4 or 5 +)	life.	Do NOT us							
MP	6th		FR	IGH	T MAII	LER	U.S.	POSTA	L SI	ERVICE	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S N	IAME (First, Middle, Mail	len Surname)			
BE	JAMES E. LEWI	S				EVANGE	ELINE BR	OWN			
70	19a. INFORMANT'S NAME (Type/Print)						I Route Number, City or				Т
	JAMES E. LEWI				777		AVE. B				
	20s, METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of competent, gremation, or other place). 20c. LOCATION — City or Town, State										
	4 Donation 5 Other (Specify) KING MEMORIAL PARK 07-13-95 RANDALLSTOWN, MD. 21. SIGNATURE OF FUNERAL SERVICE UCENSEE 22. NAME AND ADDRESS OF FACILITY										
	ALBERT P. WYLIE F/H PA										
23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory arrest,								2121	7		
	23. PART I. Enter the diseases, or shock, or heart failure.	complications that c	aused the da- on sech lina	eth. Do n	ot entar tha r	node of dying, su	ich se cardiac or re	apiratory sr	rest,	Approximata Interval Betwee	
	IMMEDIATE CAUSE (Final disease or condition									Opent and Deat	
	resulting in death)	· MULI	15y5	IGM	TKK	UMA FI	um Moto	C VERI	LLE A.	COVET 3 HO	24
		OUE TO (OI	R AS A CONSEC	UENCE OF): !	TINN	en en whi	MAD		3	
CERTIFICATION	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): B I LATGARL PICCUMO TROUBLE OF): DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): JADUS TO AND IA C CONTUSION TRANSPORT TRANSP										
ÄT	If any, leading to immediate cause. Enter UNDERLYING	BILAT	PN	Elleno	THOLEN	MED			3 Asus	,	
F	CAUSE (Disease or Injury that Initiated eventa DUE TO (OR AS A CONSEQUENCE OF):									17300	
HH	resulting in desth) LAST	TAC	- CONTUSION 3 MOU						3 HOURS	-	
CAL	LCFT BUMON	PART II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. LEFT HUMENUL FLACTURE, BLATN CONTUSION 1 YES 2 NO COMPLETION OF CAUSE OF DEATHS									
MEDI	COMPLETION OF CAUSE OF DEATH?										
Σ	HUMAN AMMUNODEFICIENCY VIRUS										
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)										
AN		HOSBITAL			OTHER:						-
SICIAN	EXAMINER?	HOSPITAL:	0.00								
HYSICIAN		1 Inpatient 2 E				ome 5 Residence		W IN HIEV OC	CHRED		
Y PHYSICIAN:	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	1 Inpetient 2 - E	IURY Year)	28b, TIME INJU	OF 26c. I	NJURY AT WORK?	28d. DESCRIBE HO			Acespart	
ВУ	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Subside	28s. DATE OF IN. (Month, Day. 28s. PLACE OF II	JURY Year) 7, 1995 JURY — At hor	28b, TIME INJU	OF 26c. I	NJURY AT WORK? YES 2 NO	MOTOL U	ISAZC	4	ACRIDENT are Number of	
ВУ	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation	28a. DATE OF IN. (Month, Day,	JURY Year) 7, 1995 JURY — At hor	28b. TIME INJU	OF 26c. I	NJURY AT WORK? YES 2 NO	28d. DESCRIBE HO	ISAZC	4		_
ВУ	EXAMINER? ZES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide a Could not be detarmined	28a. DATE OF IN. (Month, Day,	NURY Year) 7, 1995 NJURY — At hor . (Specify)	28b. TIME INJU //:/ me, farm, st	OF 26c. I	NJURY AT NORK? YES 3 NO Hoe	28d. DESCRIBE HO MOTOL U 28J. LOCATION FORE REPORT SHOWN SH	orand Humbo Ho) Mb	LC)		
ВУ	EXAMINER? 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide a Could not be detarmined 29e. CERTIFIER CERTIFYING PHYS	28e. DATE OF IN. (Month, Dey. 26e. PLACE OF II building, sto	NJURY 7, 1995 NJURY — At hor (Specify) knowledge, dar	28b. TIME INJU	OF 26c. I	NJURY AT WORK? YES 3 NO fice fice and place, and du	284. DESCRIBE HO MOTOL 284. LOCATION OFFE BIT O	or and Number	Confluence of the state of the	guns Number, ST	
COMPLETED BY	EXAMINER? 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide a Could not be detarmined 29e. CERTIFIER (Check only)	28a. DATE OF IN. (Month, Day, 26a. PLACE OF III building, atc.)	NJURY 7, 1995 NJURY — At hor (Specify) knowledge, dar	28b. TIME INJU	OF 26c. I	NJURY AT WORK? YES 3 NO fice fice and place, and du	284. LOCATION OFFI 284. LOCATION OFFI 287. LOCATION	or and Number	ted.	end menner as stated.	_
ВУ	EXAMINER? 27. MANNER OF DEATH 1	28a. DATE OF IN. (Month, Day, 26a. PLACE OF III building, atc.)	NJURY 7, 1995 NJURY — At hor (Specify) knowledge, dar	28b. TIME INJU	OF 26c. I	NJURY AT WORK? YES 3 NO flice S T ate end place, and du , death occured at th	28d. DESCRIBE HO MOTOL 28d. LOCATION Stre Cany or Your A St. Cany or Your A St. Cany or Your A St. The to the cause(s) and see time, date and place, JIMBER	orand Numbo	ted. E SIGNEO	guns Number, ST	

POSPITAL 600 N. WOLFE ST BALT MO



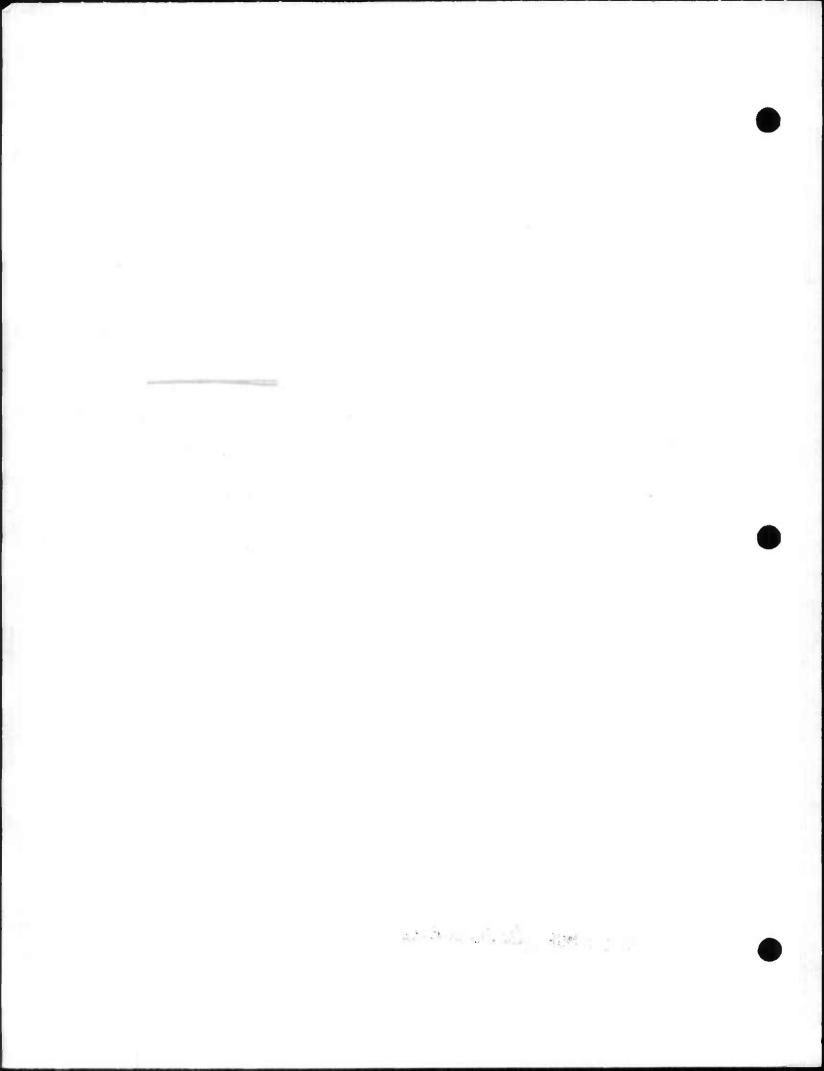
BALTIMORE, MARYLAND 21215-0020

FOR

FilmG, 725, item #18, 7/10/95 cvw. per f h

STATE	0F	MAF	RYL	AND	11	FPAR	TMF	NT	OF	HEALTH	AND	MENTAL	
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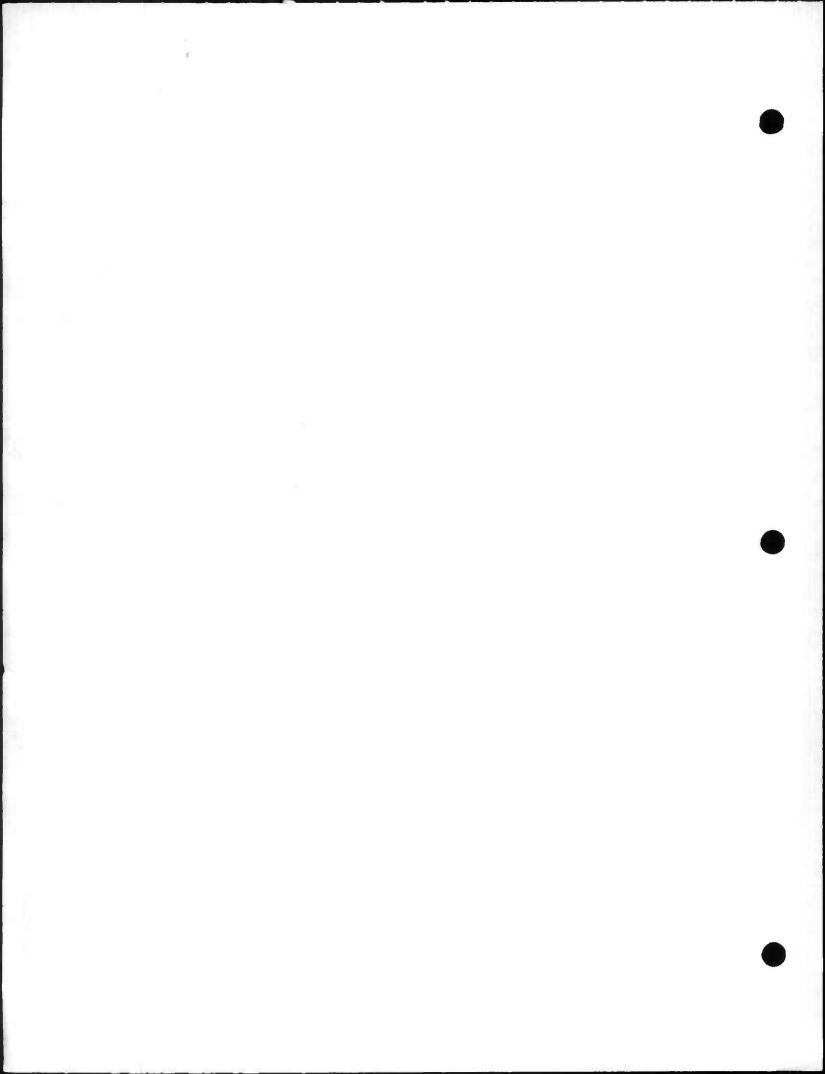
	1 - FOR STATE REGISTRAR	STATE OF MARYLAND			HEALTH AND	MENTA	AL HYGIEN REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) 1. DECEDENT'S NAME (First, Middle, Last) 8. C. C. C. C. C. C. C. C. C. C. C. C. C.	htel				J.	1240	8 9	ZEAR 3.	TIME OF DEATH
		S. SEX 6. AGE (In yrs. I	YRS.	IF UNDER 1 YEAR MONTHS DAYS		Jul	E OF BURTH Wh, Day, Year) .Y 14,	1923	Mary	
TOR	Northwest Hospi				Listown	EAIR		9c. COUNTY Balt	imor	
DIRECTOR		imore		TOWN OR LOC 1timore					1000	LIMITS? YES 2 1 NO
FUNERAL	100. STREET AND NUMBER 1426 Kirkwood Ro			1	01. ZIP CODE 21207				S.A.	COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 Married 3 XWidowed 4 Divorced	2. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 2 IF YES, GIVE WAR OR DATES		If yes, i	ECENDENT OF HISPA specify Cuban, Mexico S 2 X NO Specif	en, Puerto	IN? (Specify Yes Rican, etc.)	or No 14	Black, W Specify:	American Indian, hite, atc. White
PLETED	15. DECEDENT'S EDUCA (Specify only highest grade co Elementary/Secondary (0-12) 12th	npleted) (College (1-4 or 5+)	DECEDENT'S U (Give kind of wo fe. Do NOT use HOME M	,	TION nost of working	16	b. KIND OF BUS		TRY	
ed at once. BE COMPLET	17. FATHER'S NAME (First, Middle, Lest)	arles William			18. MOTHER'S NA			Surname)	ouise	Edelman
be notified TO BI	John H. Bechtel	1	196. MAJLING A 1426 K	irkwoo	and Number or Rural d Road		nber, City or Town Ltimore			21207
mest	20a. METHOD OF DISPOSITION 1 XI Burlal 2 Cremation 3 Remove 4 Donation 5 Other (Specify) 21. SIGNAPURE OF FUNERAL SERVICE LICEN	from State Centering C	EAND DATE OF	DISPOSITION (I	ery	1 .	12 Ba:		e, Ma	aryland
i examiner	Tuhan	2 E. K	mi	4001	and address of fa ge J. Gor Ritchie	Hwy.	Ba1t	imore	Md.	21225
event, the medical	23. PART I. Enter the diseases, or corshock, or heart failure. List iMMEDIATE CAUSE (Final disease or condition resulting in death)	polications that caused the control on a cause on each life to the control on as a consi	bral			,		ratory erree		Approximate Interval Between Onset and Deat
or other traumatic	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSI						_		DAYS
ıy inju	PART II. Other aignificant conditions of	ontributing to death but not	reauiting in	tha underlyi	ng cause given in	Part i.	24a. WAS AN PERFOR	MED?	COL	RE AUTOPSY FINOINGS ILABLE PRIOR TO MPLETION OF CAUSE DEATH?
23 s	DID TOBACCO USE CONTRIE			NO [N D			1 [YES 2 NO
or item YSICI	1 TYES 2 NO	OSPITAL: Inpetient 2 - ER/Outpetient		OTHER:	me 5 - Residence	8 🗆 Oth	er (Specify)			
marked, BY PH	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJUI	RY W M 1 □	JURY AT ORK? YES 2 NO	28d. DE	SCRIBE HOW IN	JURY OCCUR	EO	
<u>∞</u> 0	3 Suicide 6 Could not be detarmined	28e. PLACE OF INJURY — At h building, etc. (Specify)	nome, farm, str	eet, factory, off	ce	281. LOC City	CATION (Street a or Town, State)	nd Number or	Rural Route	Number,
ANT: If Item 28 COMPLETE		N: To the best of my knowledge, do							euse(a) and	I manner sa stated.
TO BE CO	29b. SIGNATURE AND TITLE OF CHITTIPIER	mo			29c. LICENSE NUM	ABER 75	0	29d. DATE SI	GNED (MO)	1th, Day, Year)
	30, NAME AND ADDRESS OF PERSON WHO CO	MORTH	EM 27) (Type, P	rint)	OSPITA	2	BAR	-71 n	nesz	
	31. DATE FILED (Month, Day, Year) JUL 1 0 1995	37 REGISTRAR'S SIGNATURE	dall							



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
=
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 -	FOR STATE REGISTRAR		STATE OF MAR	RYLAND / [CEI	DEPARTM RTIFIC	ATE OF	DEATH	MEN	REG. NO				
1.	DECEDENT'S NAME (First, Mic	iddle, Last)						2. D/	TE OF DEATH			3. TIME OF DE	ATH
			Howard	Josep	h Bro	owning	Jr.	Ju	NTH D	19	995	2:00	P.M
4.	SOCIAL SECURITY NUMBER	5	6. SEX 6. /	AGE (In yrs. last b		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DA	TE OF BIRTH		. BIRTHE	PLACE (State or	
	215 30 423	35 1	2 M 2 □ F	63	YRS. MON	THS DAYS	HOURS MIN.	Ap	ril 12,	1932	Mar	vland	
90	FACILITY NAME (If not institu	ution, give stree	et end number)		9b.	CITY, TOWN O	R LOCATION OF I			9c. COUNT		-	
<u>ج</u> ا	225 Margate	e Driv	<i>r</i> e			Glen 1	Burnie					undel	
5 🖻	ESIDENCE OF DECE									1 11111	- 111	unacı	
œ II		DE. COUNTY	3 3 . 4			WN OR LOCAT						10d. INSIDE CIT	Y
	Maryland NUMBER	Anne	Arundel		Gler	Burn						1 TES 2	
₩ W		- D				101.	ZIP CODE					HAT COUNTRY?	
FUNERAL	225 Margate						21060				S.A	•	
	Never Married 2 2 Mai		2. WAS DECEDENT EV FORCES? 1 1	YES 2 NO		13. WAS DECI	ENDENT OF HISPA	ANIC ORI	GIN? (Specify Yes to Rican, etc.)	or No-	4. RACE Black,	- American Inc White, atc.	llen,
- II -	☐ Widowed 4 ☐ Divorced		IF YES, GIVE WAR	OR DATES		1 TYES	2 NO Spec	elfy:			Specify		
	15. DECEDE	ENT'S EDUCAT	ION	16a, DECE	DENT'S USU	AL OCCUPATIO	N.		16b. KIND OF BU	SIMESS/INDI	etpv	White	:
	(Specify only hig Elementary/Secondary (0-12)	- 1	npleted) College (1-4 or 5+)	(Give	kind of work of NOT use reti	done during mos	st of working		ou. Alito of Bo.	3111233711100	37111		
COMPLETED	5			Mad	chinis	st			Koppe	rs			
Ö 17.	FATHER'S NAME (First, Middle						18. MOTHER'S N	AME (Firs	t, Middle, Maiden				
		Но	ward J. E	Browning	g Sr.				n Abig				
0 194	a. INFORMANT'S NAME (Type/	-		19b. 1	MAILING ADD	RESS (Street at	nd Number or Rura	Route N	umber, City or Tow	n, Stata, Zip C	ode)		
	LaVerne Bro	owning	<u> </u>	22	5 Mar	gate D	rive	Gle	n Burni	e, Mai	ry1a	and 210	60
	e. METHOD OF DISPOSITION XBuriel 2 Cremetion		i from State	20b. PLACE AN	D DATE OF DIS	SPOSITION /Na	me of	D	ATE 20c. LO	CATION — CH	ly or Tow	rn, State	
4.0	☐ Donation 5 ☐ Other (Spi	ecffy)		Cedar	Hill	Cemete	ry	7,	/5 Ba.	1timor	e,	Marylar	nd
21.	SIGNATURE OF FUNERAL SE	ERVICE LICEN	SEE	-	1		D ADDRESS OF F						
18	Can-	M		-									
- 4		111	man ma	110011	shi!		e J. Goi						_
23	3. PART I. Entar the disea	ases, or com	aptications that car	used the dest	h. Do not a	4001	Ritchie	Hwv	- Balt	imore	. Mc	. 2122	
	B. PART I. Enter the diseashock, or heart	T ISHUM LIS	Conly ona cause o	on each line.		4001 Inter the moo	Ritchie de of dylng, su	Hwy	Balt	imore	. Mc		nate Between
IM di:	IMEDIATE CAUSE (Final sease or condition	T ISHUM LIS	Conly ona cause o	on each line.		4001 Inter the moo	Ritchie de of dylng, su	Hwy	Balt	imore	. Mc	Approxim	nate Between
IM di	snock, or near	T ISHUM LIS	Unications that cause of DUE TO (OR	on each line.		4001 Inter the moo	Ritchie de of dylng, su	Hwy	Balt	imore	. Mc	Approxim	nate Between
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AL CERTIFICATION Section 1919 AL CERTIFICATION AL CERTIFI	snock, or near IMEDIATE CAUSE (Final sease or condition suiting in death) equantially list conditions sny, laading to immediat use. Enter UNDERLYING AUSE (Disesse or Injury at Initisted events suiting in death) LAST	s, b c d	DUE TO (OR DUE TO (OR	AS A CONSEQUI	ENCE OF):	4001 Inter the mod	Ritchie de of dylng, su	Hwy	Balt ardiec or respi	AUTOPSY MED	MC MC	Approxin interval I Onset ar Shall MARILABLE PRIOR COMPLETION OF DEATH?	FINDINGS TO CAUSE
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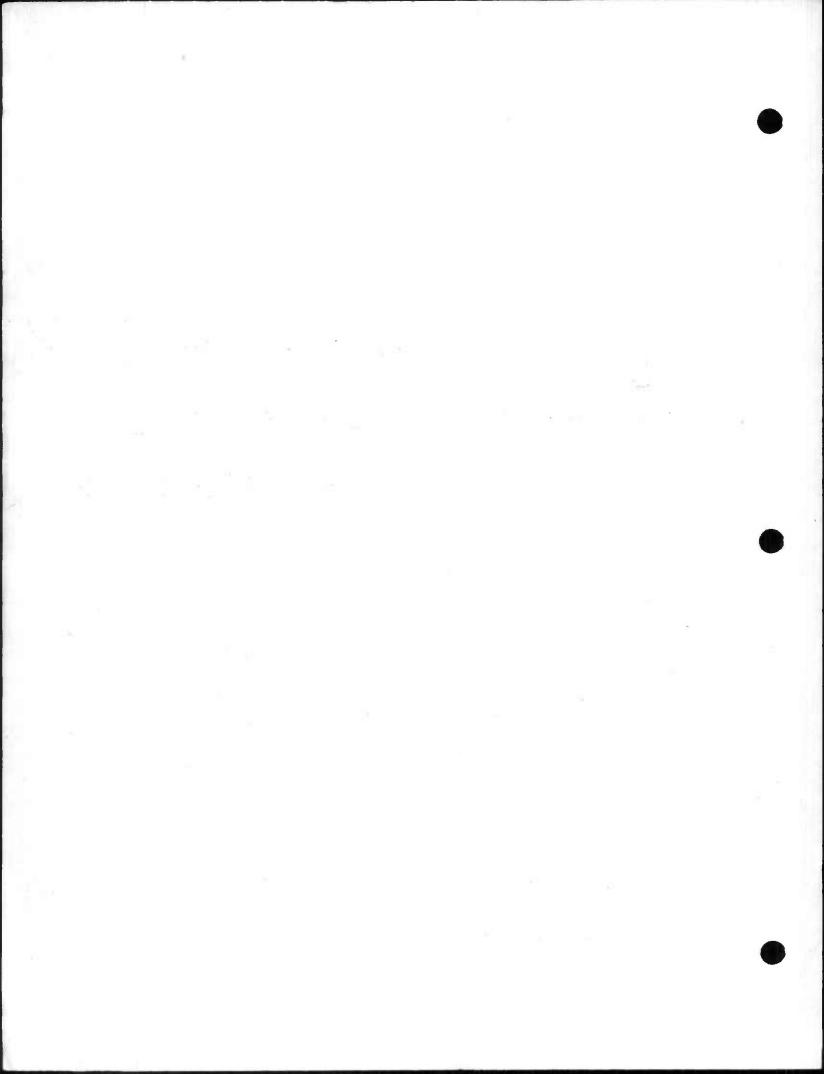
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

	1. DECEDENT'S NAME (First	Middle Leath				10/11		חבת			HEG. NO.		_	
			Briscoe,	Jr.						2. DATE O MONTH June	-		YEAR 1995	5:30 P M
	4. SOCIAL SECURITY NUMBER	_	5. SEX	8. AGE (In yrs. I	ast birthday)	IF UNDE	R 1 YEAR	IF UNDER	R 24 HRS.	7. DATE O				PLACE (State or Foreign
	220-38-166	8	1 🔀 M 2 🗆 F	53	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month,	Day, Year)	1941	Countr	nington, DC
	9a. FACILITY NAME (# not in	stitution, give s	treet and number)			9b. CIT	r, TOWN	OR LOCATI	ION OF DE		237		INTY OF D	
DIRECTOR	9485 Good Lion Road					Columbia Howard								
EG	RESIDENCE OF DEC	10b. COUNTY	1		10c, CD	Y. TOWN	OR LOCA	TION						10d, INSIDE CITY
H	MD	Howa	ırd			Colur	nbia							LIMITS?
AL	10s. STREET AND NUMBER						10	f. ZIP COD	E		-	10g. CIT	IZEN OF W	THAT COUNTRY?
FUNERAL	9485 Good	Lion	Road					210	45				USA	
5	11. MARITAL STATUS 1 Never Married 2 X	Married	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. A	RMED	13.	WAS DEC	CENDENT C	OF HISPAN	IIC ORIGIN?	(Specify Yes	or No —	14. RACE Black	— American Indian, White, etc.
B	3 Widowed 4 Divo		IF YES, GIVE V	AR OR DATES				2 X NO			,		Speci	
8	15. DEC	EDENT'S EDUC	CATION		ECEDENT'S					16b.	KIND OF BUS	INESS/IN	DUSTRY	WILLCE
COMPLETED	Elementary/Secondary (0		College (1-4 or 5	+) #	Give kind of a. Do NOT u	se retired.)				Mod	ri ono l	Two	. 4. 4. 4	+- of Moole
MP	12		4	CC	ntra	ct Ne	egot						stitu	te of Health
	17. FATHER'S NAME (First, M George R.		no Sr							ME (First, Mi L. Ba)	ddle, Maiden	Sumame)		
8	19a, INFORMANT'S NAME (7		oc, br.	1.	Ob. MAII INC	ADDRES	P /Phonest		-		r, City or Town			
2	Jacqueline	Brisco	· · · · · · · · · · · · · · · · · · ·	2)	485	Good	Lio	n Rd	. Co.	lumbi	a, MD		045	
	20a. METHOD OF DISPOSITI	ION on 3 □ Remo (Specify)	oval from State	20b. PLACI cemetery, c Metro	ematory or o	of DISPOS	SITI ON (N	ame of	July		Cato		City or To	
	21. SIGNATURE OF PUNERA	L SERVICE LIC	ENSEE /	2	02 01.	22.	NAME A	ND ADDRE	SS OF FAC	CILITY				
	Lucas		- Ste			5	555	Twin	Kno.	lls R		lumb	ia, N	Tome 1D 21045
	23. PART I. Enter the di shock, or hi	iseases, or c	complications the	t ceused tha d	eath. Do	not entai	the mo	da of dy	ing, auch	aa cardi	ac or reaple	ratory ar	reat,	Approximate interval Between
	IMMEDIATE CAUSE (Fin disease or condition	aí	A MAIN SERVICE	20,120,000			1	11 -	D					Onset and Death
	reaulting in death)	→ ,	Metasy	OR AS A CONS	my Ca	wcc y	40	The	BUAI	n				6 mults
_		_	DOE 10	(On AS A CONS	OUENCE U	-):								
9	Sequentially list conditi if any, leading to immed		DUE TO	(OR AS A CONSI	OUENCE O	F):								
CERTIFICATION	cause. Enter UNDERLYI CAUSE (Disease or inju		·										_	
	that initiated events resulting in deeth) LAS	т	DUE TO	(OR AS A CONSI	OUENCE O	F):								
B			1											
Ä	PART II. Other aignifice	nt conditions	s contributing to	death but not	resulting	in the ur	nderiyin	g ceuse g	given in i	Part i.	24a. WAS AN A		24b.	WERE AUTOPSY FINDINGS AMULABLE PRIOR TO
EDICAL										_	1 🗌 YES 2	NO		COMPLETION OF CAUSE OF DEATH?
Σ	DID TODACCO II	CE CONTE	VIDUATE TO CA				=							1 TYES 2 NO
AN I	DID TOBACCO U		GBUIE IO CA		CE OF OEA			1 UNC	ERTAIN	1	-			
SIC	EXAMINER?		HOSPITAL:			OTHE	P :	a shine	neldomes i	6 🗆 Other	(Paralla)			
PHYSICIAN:	27. MANNER OF DEATH	1 = 2	26e. DATE OF (Month, D	INJURY	26b. TIN		28c. INJ	URY AT	raidence		RIBE HOW IN	JURY OC	CUREO	
8		Pending Investigation	(Monan)	, roury		M		PRK? YES 2	NO					
ETED		Could not be determined	28e. PLACE O building,	F INJURY — A1 h etc. (Specify)	ome, farm,	street, fact	ory, offic	•		261. LOCAT	TON (Street a Town, State)	nd Numbe	or Rural R	oute Number,
9	29a. CERTIFIER	EVINC BUVE	NAM: To the best of		.00		11-0-		CESSIII) e					
COMPL			CIAN: To the best of R: On the besis of a											and manner as stated.
ŭ L	29b. SIGNATURE AND TITLE			70					ENSE NUM					(Month, Day, Year)
0 8	Michael	W.Kou	Alleles	5					850a		l		-	3047 1995
F	30. NAME AND ADDRESS OF							-					- W + + 10 ·	- 14.5
	Michael Kou	TECLAI	ws 11065		atuxe	r4P	tery	Cole	uns,	w m	1210	44		
	JUL 1 0 199	15 Jul	REGISTRA	RICHIGNATURE			1							
	2011 0 100	- ()												77



LTIMORE, MARYLAND 21215-0020
BALTIMORE
BOX 68760,
ECORDS, P.O.
LB
I OF VITA
DIVISION OF

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

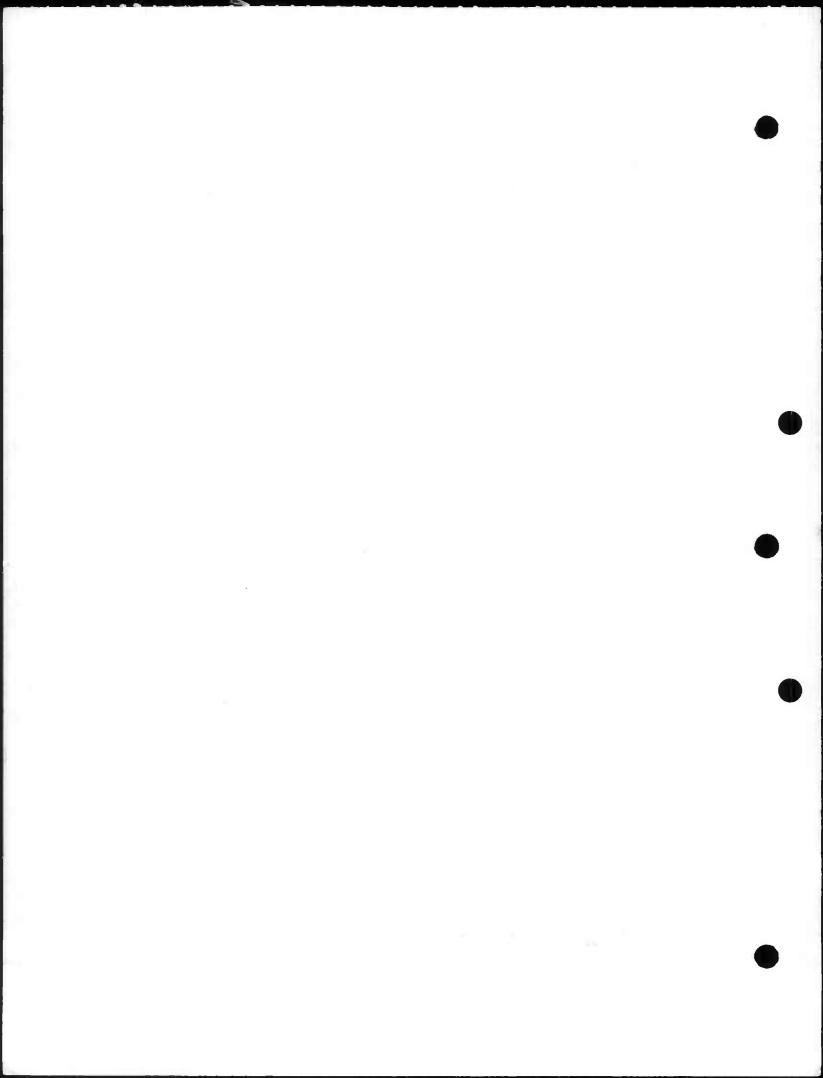
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

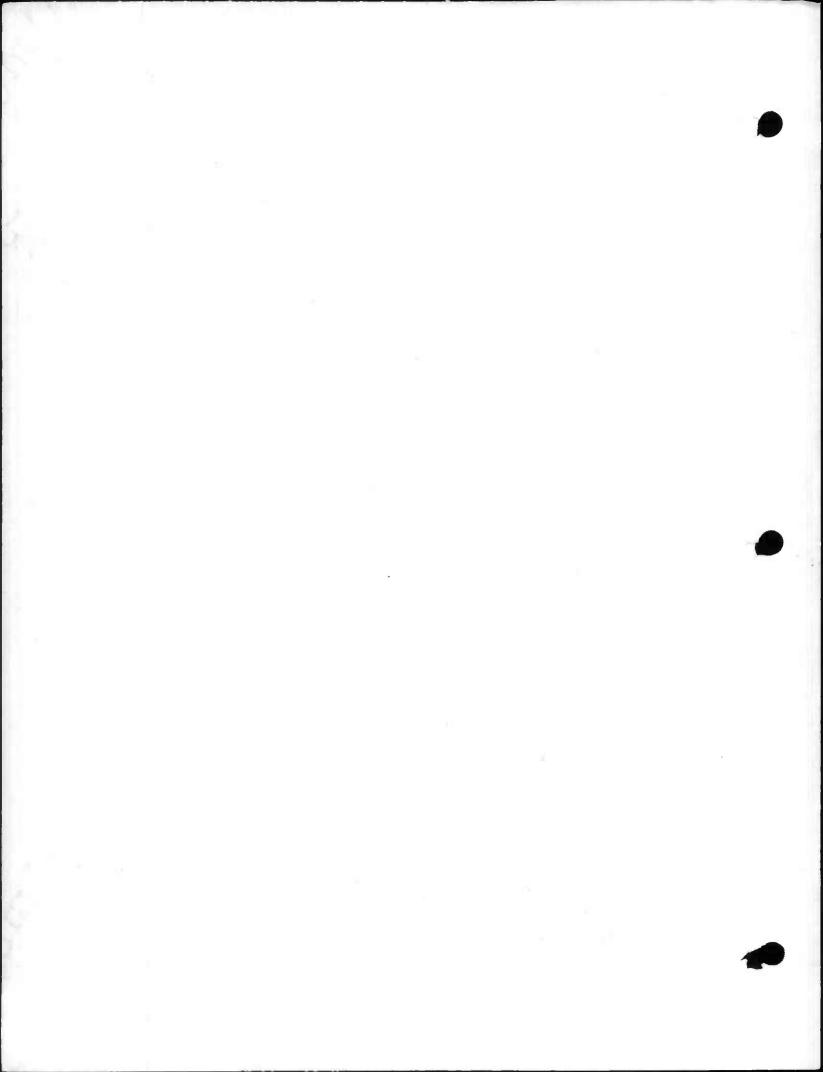
1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTM CERTIFICA	ENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)	0 0 0 10/0/		2. DATE OF DEATH DAY	3. TIME OF DEATN
4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In vis. Inst birthday) F		07/03/4	5 4.20 pm
220-20-3209	1 M 2 KF 68 YRS. MON	UNDER 1 YEAR IF UNDER 24 HRS. ITHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	BIRTNPLACE (State or Foreign Country)
90. FACILITY NAME (If not institution, give stre	11-00	CITY, TOWN OR LOCATION OF DE		Y OF DEATH
RESIDENCE OF DECEDENT	MOSPITAL	BACTO.	75	ACIO.
100. STATE TOO. COUNTY	(40. BA	WN OR LOCATION LTLMORE		10d, INSIDE CITY LIMITS? 1 YES 2 NO
10s. STREET AND NUMBER		10f. ZIP CODE	10g. CITIZE	N OF WHAT COUNTRY?
11. METTLE	TON LOURT 12. WAS DECEDENT EVER IN U.S. ARMED	12124	tu	SA
1 Never Married 2 Married	FORCES? 1 YES 2 NO	If yes, specify Cuben, Mexice 1 YES 2 NO Specify	n, Puerto Rican, atc.)	4. RACE — American Indian, Black, White, etc.
3 X Widowed 4 Divorced				Specify: BLACK
15. OECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	ompleted) (Give kind of work of	done during most of working	16b. KIND OF BUSINESS/INDUS	STRY
Living the year of the secondary (0-12)	College (1-4 or 5+) NA DISAR	43)6	NA	
17. FATHER'S NAME (First, Middle, Last)	200	16. MOTNER'S NA	ME (First, Middle, Malden Surneme)	
190. INFORMANT'S NAME (Type/Pyint)	JAROX	VANI	la Sampso	
Michelle B	ROWN III NE	TTLETON	Route Number City or Town, State, Zip C	Hd 21244
20s METHOD OF DISPOSITION 1 Suriel 2 Cremation 3 Ramov	ral from State 20th PLACE AND DATE OF DIS	SPOSITION (Name of	DATE 20c LOCATION - CH	ty or Town, Stata
Donetion 6 Other (Specify)	King Mei	1 Pour	71/10/95 Randull	stown, md
21. SIGNATURE OF FUNERAL SERVICE LICE	B- Cott	22. NAME AND ADDRESS OF FA		15 HA 21815
23. PART Enter the diseases, or co	mplications that caused the death. Do not e	enter tha mode of dying, such	h as cardiac or respiratory arres	it, Approximate
IMMEDIATE CAUSE (Final	st only Dna deuse on each line.		*	Interval Between Onset and Death
disease or condition resulting in death) e.	Congestive &	tear He	eller	18 chy
	DUE TO (OR/AS A CONSEQUENCE OF):	y Fibro	1	/1
Sequantially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEQUENCE OF):	10 . 1:	14	
cause. Entar UNDERLYING CAUSE (Disease or Injury	Dilottol	Carolion	my whathy	
that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):			
d.				
Hr-5 to a	contributing to deeth but not resulting in the		Part I. 24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
113100	M. d i . L . V.	Boundary I f	1 YES 2 1 NO	OF DEATH?
DID TOBACCO USE CONTRI	BUTE TO CAUSE OF DEATH YES	NO IXI UNCERTAIN	Diagram	1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF DEATN (C)	heck only one)		
1 TYES 2 NO		HER: Nursing Nome 5 - Residence	6 Other (Specify)	
27. MANNER OF DEATN 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE NOW INJURY OCCU	RED
2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY — At home, farm, street,	M 1 YES 2 NO	281. LOCATION (Street end Number or	Rural Bouta Number
4 Nomicide 6 Could not be determined	building, atc. (Specify)	,,,,,,,	City or Town, State)	The state of the s
290. CERTIFIER (Check only	AN: To the best of my knowledge, death occurred at	the time, date end placa, end dua	to the cause(e) end manner ee stated	
	On the basis of axamination and/or investigation, in	my opinion, death occured at the	time, data and place, end due to the	ceuse(a) end manner ee stated.
29h. SADMATURE AND TITLE OF CERTIFIER	L MIN	29c. LICENSE NUN	BER 29d. DATE S	SIGNED (Month, Day, Year)
30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)	115	33 7	13/95
CHRYSOLOG	-UR GAKUBA		ervoir and	le, Pikegville
31. DATE FILED (Month, Day, Year)	37 REGISTRAR'S GNATURE	/	MA	21208.



ALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68769 BALTIMORE, MARYLAND 21215-0020	020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the mount after death. Page 6 may be retained by the hospital or attending physician.	physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, cremation, or removal.	burial-transit permit. Pages 1, 2, 3 should
IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

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	1 - FOR STATE REGISTRAR	STATE OF MA	ARYLAND / DEP CERT	ARTMENT OF			YGIENE EG. NO.	
8	1. DECEDENT'S NAME (First, Middle, Last)			_		2. DATE OF E		YEAR 3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	Jerome	Black			July	4 199	95 6.30 A M
	216-54-4657	5. 9EX	8. AGE (In yrs. lest birthdo	MONTHS DAY		7. DATE OF B	(Year)	8. BIRTHPLACE (State or Foreign Country)
	90. FACILITY NAME (If not institution, give a	^-	-1-1		N OR LOCATION OF	Sept 3		UNTY OF DEATH
TOR	2934 Round Roa			Balti				1/A
DIRECTOR	10a. STATE 10b. COUNT	N/A	10c.	Baltimo				10d. INSIDE CITY LIMITS? 1 X YES 2 NO
FUNERAL	100. STREET AND NUMBER 2934 Round Road				101. ZIP CODE 21225			S A
BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA	EVER IN U.S. ARMED YES 2 ND R OR DATES	If yes,	ECENDENT OF HISP specify Cuben, Mexi ES 2 X NO Spec	can, Puerto Ricen	pecify Yes or No-	14. RACE — American Indian, Black, White, etc. Specify:
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	completed)	(Give kind	I'S USUAL OCCUPY of work done during Tuse retired.)	TION most of working	16b. KIN	D OF BUSINESS/IN	IDUSTRY
MPL	12th gradé	College (1-4 or 5+)	Orde	r Filler		Elec	trial Wa	rehouse
	17. FATHER'S NAME (First, Middle, Last)	. 1 1					, Meiden Surneme)	
R	Eddie Lee Blackw	ell				ia Jone		
5	Deborah Blackwel	1	293	4 Round	Road Ba		, Md 212	225
	20a. METHOD OF DISPOSITION \$\(\sum_{\text{X}} \text{Burie!} \ 2 \subseteq \text{Cremetion} \ 3 \subseteq \text{Rem} 4 \subseteq \text{Donatton} \ 6 \subseteq \text{Other} \((\subseteq \subseteq \text{Cocity} \)	oval from State	20b. PLACE AND DA			7895	Arbutus	- City or Town, State
	21. SIGNATURE OF FUNERAL SERVICE LIK	CENSEE	Mibacas	22. NAME	AND ADDRESS OF	FACILITY	71 Ducus	, nu
	· Dun	is D.	Dest	430	ch F/H W O Wabas	h Avenu	e Baltin	nore, Md 21215
	23. PART Enter the diseases, or shock, or heart tallure.	complications that	caused the death. D	o not anter the	noda of dying, su	ich as cardiac	or reapiratory a	rrest, Approximate interval Between
	iMMEDIATE CAUSE (Final disease or condition resulting in death)	Cli	nte M	yo care	11].	fact to		Onset and Death
		DUE TO (C	OR AS A CONSEQUENCE	OF):	1	1. Ha.	FD.	
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	b. OUE TO (C	OR AS A CONTEQUENCE	m W	www.	- 1/200	1/94	
2	CAUSE (Disease or injury	C	A					
	that initiated events resulting in death) LAST	d	OR AS A CONSEQUENCE	: OF):				
MEDICAL C	PART II. Other aignificant condition	Failure	sath but not resulting	ig in the underly	ing cause given i	n Part I. 24a	. WAS AN AUTOPSY PERFORMED?	AMAILABLE PRIOR TO
	0 - 0 - 12,) 000		341		10	YES 2 4NO	COMPLETION OF CAUSE OF DEATH?
	DID TOBACCO USE CONT	RIBUTE TO CAU	ISE OF DEATH	YES NO	UNCERTA	IN \square		1 TES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			EATH (Check only or				
SIC	1 VES 2 NO	HOSPITAL:	ER/Outpatient 3 DO	OTHER:	ome 5 Residence	6 Other (Spi	acify)	
PH	27. MANNER OF DEATH 1 Natural 5 Pending	26e. DATE OF III (Month, Day	NJURY 26b.	INJURY	NJURY AT WORK?	26d. DESCRIE	E HOW INJURY O	CCURED
B	2 Accident Investigation	26e PLACE OF	INJURY — At home, fer		YES 2 NO	284 LOCATION	N (Count and March	0.10.14
TED	4 Homicide 6 Could not be determined	building, et	Ic. (Specify)	n, andet, lectory, o	1100	City or Tox	vn, Stete)	er or Rural Route Number,
COMPLETE			ny knowledge, death occ					
00			mination end/or investig	ition, in my opinior				the ceuse(e) and menner ee stated.
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIE	1 en	> P.	up mi	29c. LICENSE N	9212	29d. DA	TE SIGNED (MOSTI, Dew Your)
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DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit bours after death with the State Deat, of Health and Mental Hydiere prior to burial, cremation, or cannot	tem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
ATT	ECTO IS aft	n 28
DR	BIO IN	e

Pages 1, 2, 3 should

ITEM: 18. PER F'.H. F'ILM G-733 3/29/96 t.t FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 Patricia Ann Boswell July 06, 4:45 P 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign 1 M 2 TYF 214-48-2172 50 Aug. 02,1944 Maryland 9a. FACILITY NAME (If not institution, give street and number, 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH 4300 Powell Ave. Baltimore City DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore City Maryland N/A 1 X YES 2 NO FUNERAL . STREET AND NUMBER 101. ZIP CODE 21206 10g. CITIZEN OF WHAT COUNTRY? 4300 Powell Ave. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuben, Maxican, Puerto Rican, atc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White BY 3 Widowed 4 Divorced 6 tee. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) Settlement Officer Banking 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Christian Nagel Margaret Joitis JOSITIS BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. Donald M. Boswell 4300 Powell Ave. Baltimore, Maryland 21206 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Gardens of Faith Cem. 7-08-95 Baltimore Co. Maryland 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. Jeffrey L. Gair ave 0 5305 Harford Road Baltimore, Maryland 21214 23. PART (Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, andck, or hear reliure. List only one cause on each line. interval Betwe **IMMEDIATE CAUSE (Fine)** Onset and Death disease or condition METASTATIC UTGRING UCIONYOSALCOMA 2 405 reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): PULLOWARY INSUPPICIENCY nos CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 W NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐ 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 - YES 2 X NO ☐ Inpetient 2 ☐ ER/Outpetlent 3 ☐ DOA 4 - Nursing Homa 5 Realdence 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 28s. PLACE DF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED 8 Could not be 4 Homicide 29a. CERTIFIER

(Chack and) 1 K CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and manner as stated. COMPL 2 MEDICAL EXAMINET: On the beels of examination and/or investigation, in my opinion, desth occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) wall Ma Pha 546104 7175 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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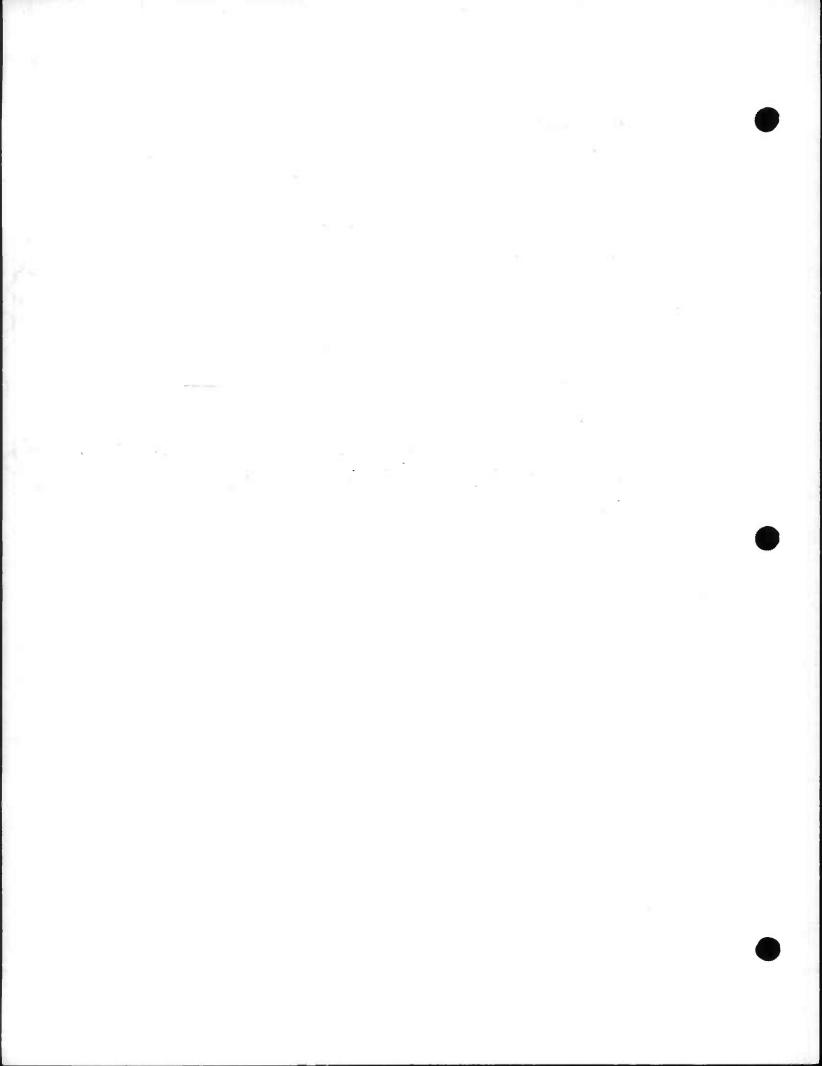
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		DECEDENT'S NAME (First, Middle, Last) IRMA	V.	BOND			2. DATE	OF DEATH	5 YE		TIME OF DEATH 9:37 am
P		4. SOCIAL SECURITY NUMBER 215-01-2085	1 M 2 🔀 F	yrs. last birthday) 81 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE (Month	of BIRTH 5 191:	3	Country)	ACE (State or Foreign
2, 3 should	TOR	98. FACILITY NAME (If not institution, give st Saint Joseph Medic				on, Maryli			9c. COUNTY Baltin	OF DEAT	Н
permit. Pages 1, 3	DIRECTOR	100. STATE 100. COUNTY Md. Bal	timore		Y, TOWN OR LOCATO	TION					d. INSIDE CITY LIMITS? X YES 2 NO
nsit.	FUNERAL	204 East Joppa	Rd. # 717		10	21286			USA	OF WHAT	T COUNTRY?
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YLAND 212- by the hospital or att be detached for use at once.	СОМР	12 17. FATHER'S NAME (First, Middle, Last)		Secrat	ary	18. MOTHER'S NA	AME (First, A			ту	
MARYL retained by 5 should be notified at	TO BE	Jacob Singnass Mary Grant									
5 6 0		20a. METHOO OF DISPOSITION 1A Burlat 2 Cremation 3 Remo		LACE AND DATE	of Disposition (National Control Contr	ama of	-8-95	E 20c. LOCA	TION — CHY	or Town,	
BALTIMORE, after death. Page 6 may be yy the funeral director, page moval. cal examiner must be		21. SIGNATURE OF FUNERAL SERVICE LICE	PS		1050	Towson York Re	d. To				
hours aft ed in by or remo		23. PART I. Enter the disease, or c shock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in deeth)	omplications that caused to lat only one cause on sectors SEPTIC SHOCK	h line.	not sntsr the mo	ds of dying, suc	ch aa cerd	llsc or respirat	tory errest,		Approximate interval Between Onset and Death HOURS
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o the	HYSI	1 YES 2 NO	MOSPITAL: 1 Inpatient 2 ER/Outpati			e 5 Rasidence	1				
	BY PI	Netural 5 Pending Accident Investigation	(Month, Day, Year)	28b. TIM INJ	URY WO	VES 2 NO	28d. DEŞ	CRIBE HOW INJ	JRY OCCURE	D	
ISIC TTENDI TTOR: A after d		3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office 28t. LOCATION (Street and Number or Rural Route Number of Rural Route Number o								Number,	
로 로 로 드	COMPLET		NAN: To the best of my knowled t: On the basis of examination a							use(a) an	d manner as stated.
TO THE HOSPI TO THE FUNER TO FIRED WITHIN	H 4	296 SIGNATURE AND TITLE OF CERTIFIER	- in Ricum	mo		29c. LICENSE NU D 31826			Ped. DATE SIG		nth, Day, Year)
10	TO	30. NAME AND ADDRESS OF PERSON WHO RICHARD L. LINTHIC	COMPLETEO CAUSE OF OEATH	YORK R	OAD TOV	VSON, MA	ARYLA		-		
10		31. DATE FILED (Month, Day You's	32. TEGISTIAN'S SPIATI	54							

3. TIME OF DEATH

2. DATE OF DEATH DAY

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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MARGARET BLACK Jul 8 1995 KARY 8:05 pm 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign (Month, Day, Yea 7/22/17 1 M 2 V F 215-03-8567 Maryland Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Saint Joseph Medical Center DIRECTOR Towson, Maryland Baltimore RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland N/A Baltimore 1 XYES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4401 Frankford Ave. 21206 use as the burial-transit U.S.A. attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO BY Specify: 3 Widowed 4 Divorced White 16a. DECEOENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EOUCATION (Specify only highest grade completed) 16b. KING OF BUSINESS/INCUSTRY (Give kind of work done during life. Do NOT use retired.) hospital or detached for Elementary/Secondary (0-12) College (1-4 or 5+) 12 Housewife Own Home once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surneme) the Samue1 Warns N Goldie Hoshall à BE notified 5 should 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. Richard J. Black 3202 Moravia Rd., Baltimore, Maryland 21214 page 9 20e. METHOO OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must director, Moreland Memorial Park 7-12-95 4 Donation 8 Othe Baltimore, Maryland examiner 21. SIGNATONE OF FUN 22. NAME AND ADDRESS OF FACILITY it funeral Leonard J. Ruck, Inc. Ernest 5305 Harford Rd., Baltimore, Md. 21214 the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory strest, filled in by t Approximate shock, or heart fallure. List only one cause on each line. Interval Batwe ō IMMEDIATE CAUSE (Final Onset and Death cremation, the disease or condition CHRONIC OBSTRUCTIVE PULMONARY DISEASE pletely traumatic event, resulting in death) 10 years DUE TO (OR AS A CONSEQUENCE OF): HYPERTENSION and corr COFF CERTIFICATION Sequentially list conditions, PERIPHERAL VASCULAR DISEASE 9 if any, leading to immediate prior csuse. Enter UNDERLYING CAUSE (Disease or injury other attending phys DUE TO (OR AS A CONSEQUENCE OF) that initieted events resulting in death) LAST 0 the atten Mental I PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL signed by the shows any 1 YES Z NO OF DEATH? 1 TES 2 NO been DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Item certificate h HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER: 4 Nursing Home 5 Residence 8 Other (Specify) 9 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? marked, 28d. DESCRIBE HOW INJURY OCCURED this (Natural 5 Pending Investigation 1 YES 2 NO BY After death HOSPITAL OR ATTENDING 2 Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 60 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be hours after Item 28 is DIRECTOR: 4 Homicide determined 29a, CERTIFIER 1- CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) and manner se stated. TO THE HOSPITAL (
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DE filed within 72 h
IMPORTANT; If It 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner se stated. 296. SIGNATURE AND JITLE OF GERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE D37254 SW 9 08 2 30. NAME AND ADDRESS OF PERSON WIND COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BOON P. LIM, M.D. 7620 Jork Rd TOWSON, MD 21204 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
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DIRECTOR: After this certificate has been signed by the attending physician and completely thours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation

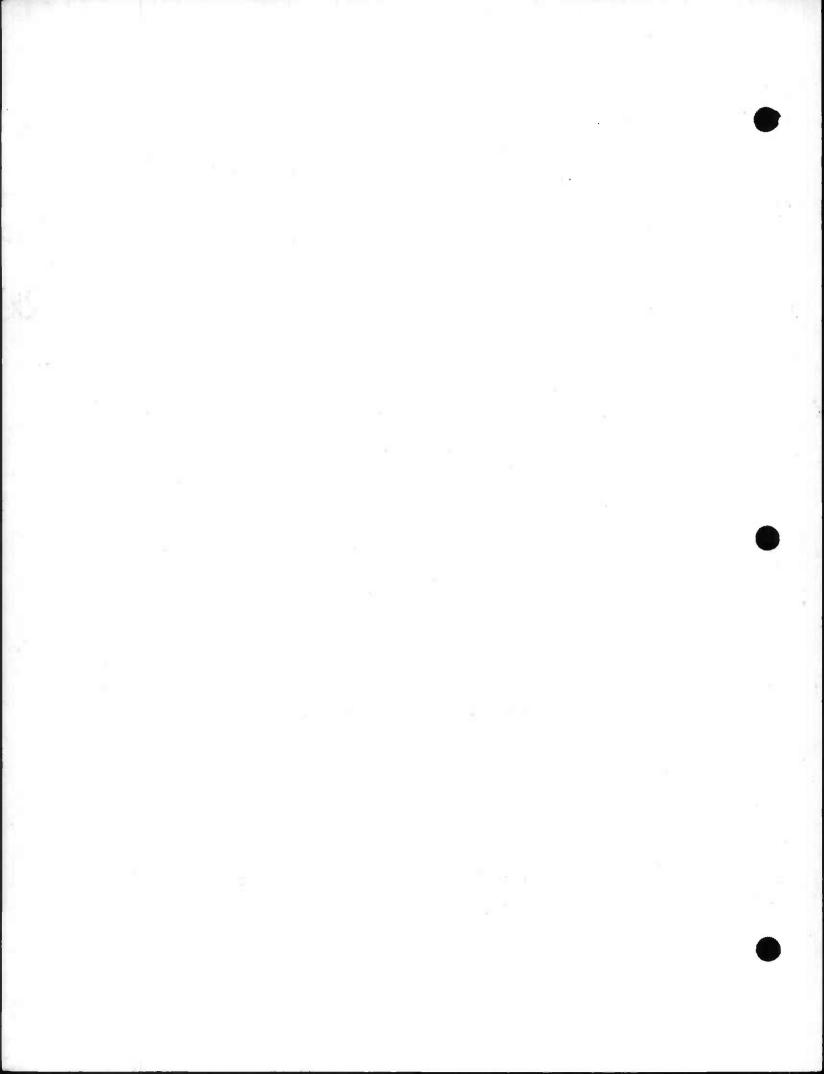
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NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

JODES

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH JUL 1 LEND 30UCK 1611 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) Sep 27 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 220-12-9893 1 🗌 M 2 💢 🕏 81 YRS. Ohio 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH FUNERAL DIRECTOR 854-ASAdeNA JENKIN 5 RESIDENCE OF DECEDENT 10a STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Anne Arundel Pasadena 1 TES 2 NO 104 STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8547 Jenkins Rd. 21122 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 YES 2 NO Specify: 14. RACE — American Indian, Black, While, etc. 1 Never Married 2 Married BY Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Household once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elton notified at Bowles Elizabeth Smith BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8547 Jenkins Rd. Pasadena, Md. 21122 Erma G. Ellecamp pe 20s. METHOD OF DISPOSITION
1 □ Burial 2 □ Cremation 3 □ Ramoval from State
4 □ Donation 5 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must "Metro"Crematory Inc. 7/8 Baltimore, Md. examiner Stallings Funeral Home PA 21. SIGNATURE OF FUNERAL SEBVICE LICENSEE 3111 Mountain Rd. Pasadena, Md. 21122 medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert failure. Just only one cause on each line. Approximata interval Between IMMEDIATE CAUSE (Final Onaat and Death other traumatic event, the Pardio - Respiratory
DUE TO (OR AS A CONSEQUENCE OF): disease or condition resulting in death) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST 10 23 shows any injury, PART ii. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 1 TYES 2 NO OF DEATH? 1 TYES 2 T NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only or ltem me **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpetient 3 | DOA 4 ☐ Nursing Home 5 X Residence 8 ☐ Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED is marked, 1 Natural 1 YEB 2 NO BY Investigation 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 200 4 Homicide Hem 29a, CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. TO THE HOSPITAL OF THE FUNERAL D DE filed within 72 ho 2 MEDICAL EXAMINER: On the basis of in and/or investigation, in my opinion, death occured at the time, data and placa, and dua to the cause(a) and manner as stated, 29d. DATE SIGNED (Month, Day, Year) BE Deputy D06054 95

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within
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1 - FOR STATE REGISTRAR	STATE OF MARY									
· ·					2. DATE OF DEATH		3. TIME OF DEATH			
					July 1,19	995	12:02P M			
217–24–9518	1 ☑ M 2 □ F	66 YRS.	ONTHS DAYS	HOURS MIN.	(Month, Day, Year) 7-13-28	°	NRTHPLACE (State or Foreign country) WVA			
4227 Slater A	ve.				ATH		Itimore			
Md 106. COUN	Baltimore	10c. CITY,					10d. INSIDE CITY LIMITS? 1 YES 2 NO			
100. STREET AND NUMBER 4227 Slater Ave	e.		101.	21236			OF WHAT COUNTRY?			
11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 TYPES	S 2 NO	tf yes, spe	ecify Cuban, Maxicar	, Puerto Rican, etc.)		RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S ED (Specify only highest gra-	DUCATION ade completed) College (1-4 or 5 +)	(Give kind of wor	k done during mos	ON ist of working	16b. KIND OF BUS	SINESS/INDUSTI	RY			
12	3	Insura	ince Age	ent	Diversified Insurance					
Charles H. Chil	lcote Sr.			Ruth 2	immerman					
Patricia Chilco		4227 S	Slater A	Ave.White	Marsh, M	2123	6			
1 Suriat 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gardens Of Faith 7-6-95 Baltimore, MD										
Cvach/Rosedale Funeral Home 1211 Chesaco Ave.										
iMMEDIATE CAUSE (Final disease or condition resulting in desth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST	DUE TO (OR AS	A CONSEQUENCE OF):				<i>N</i>	Onset and Death 10 MIN. 6 YRS. 2 YRS.			
PART II. Other significent condition	ons contributing to deeth I	but not resulting in	the underlying	g cause given in f	PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
	TRIBUTE TO CAUSE (UNCERTAIN		-, -	1 TYES 2 NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	C	THER:	- E Youtdones	- Clarker (Procedu)					
27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME (OF 28c. INJU	URY AT		JURY OCCURE	D			
2 Accident Investigation 3 Suicide 6 Could not be determined										
	YSICIAN: To the best of my know						se(a) and menner as stated.			
2 MEDICAL EXAMI										
29b. SIGNATURE AND TITLE OF CERTIFI	IER COON	V	u.D.	29c. LICENSE NUM	7 1 8	29d. DATE S10	NED (Month, Day, Year)			
	~ (00 ^	EATH (ITEM 27) (Type, Pr	u.D.	29c. LICENSE NUM	728 Ba Yir	Dung, M	/3/95			
	1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Las Charles 4. SOCIAL SECURITY NUMBER 217-24-9518 6a. FACILITY NAME (If not institution, give 4227 Slate!" Ave 10b. COUNTY NOT 10b. STATE 10b. COUNTY 10c. STATE 10b. COUNTY 10c. STATE 10b. COUNTY 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 15. DECEDENT'S E (Specify only highest gre Elementary/Secondary (0-12) 12 17. FATHER'S NAME (First, Middle, Last) Challes H. Chi	1. DECEDENT'S NAME (First, Middle, Last) Charles H. 4. SOCIAL SECURITY NUMBER 217-24-9518 S. SEX 1 M 2 D F 6a. FACILITY NAME (If not institution, give street and number) 4227 Slater Ave. RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. STREET AND NUMBER 4227 Slater Ave. 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 1947-19 16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (b-12) 17. FATHER'S NAME (First, Middle, Last) Charles H. Chilcote Sr. 19a. INFORMANT'S NAME (First, Middle, Last) Charles H. Chilcote 20a. METHOD OF DISPOSITION 1 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE INCENSEE ADDITION CAUSE (Final disease or condition resulting in desth) PART II. Other significent conditions resulting in desth) DUE TO (OR AS A. S. O DUE TO (OR AS DUE TO (OR AS A. S. O DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS A. S. O DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS A. S. O DUE TO (OR AS DEPLICATION OR DEPORTED OR DUE DEPORTED OR DUE DEPORTED OR DUE DEPORTED OR DUE DEPORTED OR DUE DEPORTED OR DUE DEPORTED OR DUE DEPORTED OR DUE DEPORTED OR DUE DEPORTED OR DUE DEPORTED OR DUE DEPORTED OR DUE DEPORTED OR DUE DEPORTED OR DUE DEPORTED OR DUE DEPORTED OR DUE DEPORTED	1. DECEDENT'S NAME (First, Middle, Lest) Charles H. Chilcote 1. DECEDENT'S NAME (First, Middle, Lest) Charles H. Chilcote 1. Charles H. Chilcote 1. A. SOCIAL SECURITY NUMBER 217-24-9518 1. May 2 F	1. DECEDENT'S NAME (First, Middin, Last) Charles H. Chilcote Jr. 4. SCOLAL SECURITY NAME (First, Middin, Last) 66 VRS. 1. PAGE IN PR. SECURITY NAME (First, Middin, Last) 4. SOCIAL SECURITY NAME (First, Middin, Last) 66 VRS. 66 VRS. 66 VRS. 67 VRS. 68. FACILITY NAME (First in institution, pive street and number) 4. 22.7 Slater Ave. PRESIDENCE OF DECEDENT Married 100. STATE 100. COUNTY MO. 11. MARITAL STATUS 1 Never Married 2. Married 3 Widdowed 4 Divorced 1 Never Married 3 Widdowed 4 Divorced 1 Never Married 3 Widdowed 4 Divorced 1 Never Married 3 Widdowed 4 Divorced 1 Never Married 3 Widdowed 4 Divorced 1 Never Married 3 Widdowed 4 Divorced 1 Never Married 3 Widdowed 4 Divorced 1 Never Married 3 Widdowed 4 Divorced 1 Never Married 3 Widdowed 4 Divorced 1 Never Married 3 Widdowed 4 Divorced 1 Never Married 3 Widdowed 4 Divorced 1 Never Married 3 Widdowed 4 Divorced 1 Never Married 3 Widdowed 4 Divorced 1 Never Married 3 Widdowed 4 Divorced 1 Never Married 3 Widdowed 4 Divorced 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married	1. DECEDENT'S MARK (First, Micking, Last) Charles H. Chilcote Jr. 4. SOCIAL SECURITY NUMBER 2.17-24-9518 3. SEX 6. AGE (in ym. last birthody) FUNCES I YEAR FUNCES I YEAR FUNCES I YEAR 2. TOWN HOLDSTON OF DE VINITE FUNCES I YEAR 2. TOWN HOLDSTON OF DE VINITE 4. DECEDENT YEAR 7. TOWN OR LOCATION OF DE VINITE 7. TOWN OR LOCATION OF DE VINITE 7. TOWN OR LOCATION OF DE VINITE 7. TOWN OR LOCATION OF DE VINITE 7. TOWN OR LOCATION OF DE VINITE 7. TOWN OR LOCATION OF DE VINITE 7. TOWN OR LOCATION OF DE VINITE 7. TOWN OR LOCATION OF DE VINITE 7. TOWN OR LOCATION OF DE VINITE 7. TOWN OR LOCATION OF DE VINITE 7. TOWN OR LOCATION OF DE VINITE 7. TOWN OR LOCATION OF DE VINITE 7. TOWN OR LOCATION OF DE VINITE 7. TOWN OR LOCATION 7. TOWN OR LOCATION 7. TOWN OR LOCATION OR DE VINITE 7. TOWN OR LOCATION OR DE VINITE 7. TOWN OR LOCATION OR LOCATION OR DE VINITE 7. TOWN OR LOCATION OR LOCATION OR DE VINITE 7. TOWN OR LOCATION OR LOCATION OR LOCATION OR LOCATION OR LOCATION OR LOCATION OR LOCATION OR LOCATION OR LOCATION OR LOCATION 7. TOWN OR LOCATION	CERTIFICATE OF DEATH DECORDET NAME (First, Modes, Law) Charles H. Chilcote Jr. 1. OCTOBER NAME (First, Modes, Law) Charles H. Chilcote Jr. 1. OCTOBER NAME (First, Modes, Law) 1. OCTOBER NAME (First, Modes, Mades) 1. OCTO	1. DECERTIFICATE OF DEATH REG.NO. 1. DECERTIFICATE OF DEATH REG.NO. CRAFT (CATE OF DEATH REG.N			

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FilmG, 725, item #1, 7/10/95,cyw, per f.h. FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO 1. DECEDENT'S NAME (First, Middle, Last) HELEN ELI 2. DATE OF DEATH 3. TIME OF DEATH teler Etizabeth MONTH 5: 45 Am AUGHTUD. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. October 15, 1919 Illinois 327-20-4541 75 1 M 2 X F YRS. Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR St. Agnes Hospital Baltimore N/A RESIDENCE OF DECEDENT 10e. STATE 19c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Catonsville 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 915 Kent Avenue 21228 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, atc. 1 Never Merried 2 Merried
3 Widowed 4 Divorced If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 24 NO Specify: Specify White BY COMPLETED 15. DECEDENT'S EDUCATION 16a, DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Arthur H. Moberly To Jewell Pitts BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Bette Calhoon (daughter) 915 Kent Avenue Catonsville, Maryland 21228 9 20g: METHOD OF DISPOSITION
1 1 2 Burlel 2 Cremation 3 Removal from State
4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE must Deland Cemetery July 13, 1995 Deland, Illinois examiner 22. NAME AND ADDRESS OF FACILITY
Leroy M. & Russell C. Witzke Funeral Home
1630 Edmondson Avenue Catonsville, Maryland 21228 21. SIGNATURE OF FUHERAL SERVICE LICENSEE 23. PART I. Eafer the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory street, shock, or heart failure. List only one cause on each line. medical Approximate Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition resulting in dasth) ASPIRATION DUEN WONIA m event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentisity list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, laading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 6 PART II. Other significent conditions contributing to desth but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS WAILABLE PRIOR TO Obtenyelity Rhomeford trothertis any Drewhites COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Shows mobile tes melli fus 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL Item 2 HOSPITAL: OTHER:
4 Nursing Home 5 Residence 8 Other (Specify) 1 YES 2 NO 1 Inpatient 2 - ER/Outpetient 3 - DOA 6 27. MANNER-OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, term, atreet, factory, office building, etc. (Specify) ... 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 28 Hem 29e, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: I 2 __ MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 206. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) B Houlearly whombo

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

AT MAIN TO LAW KOW INC., CT ACMES



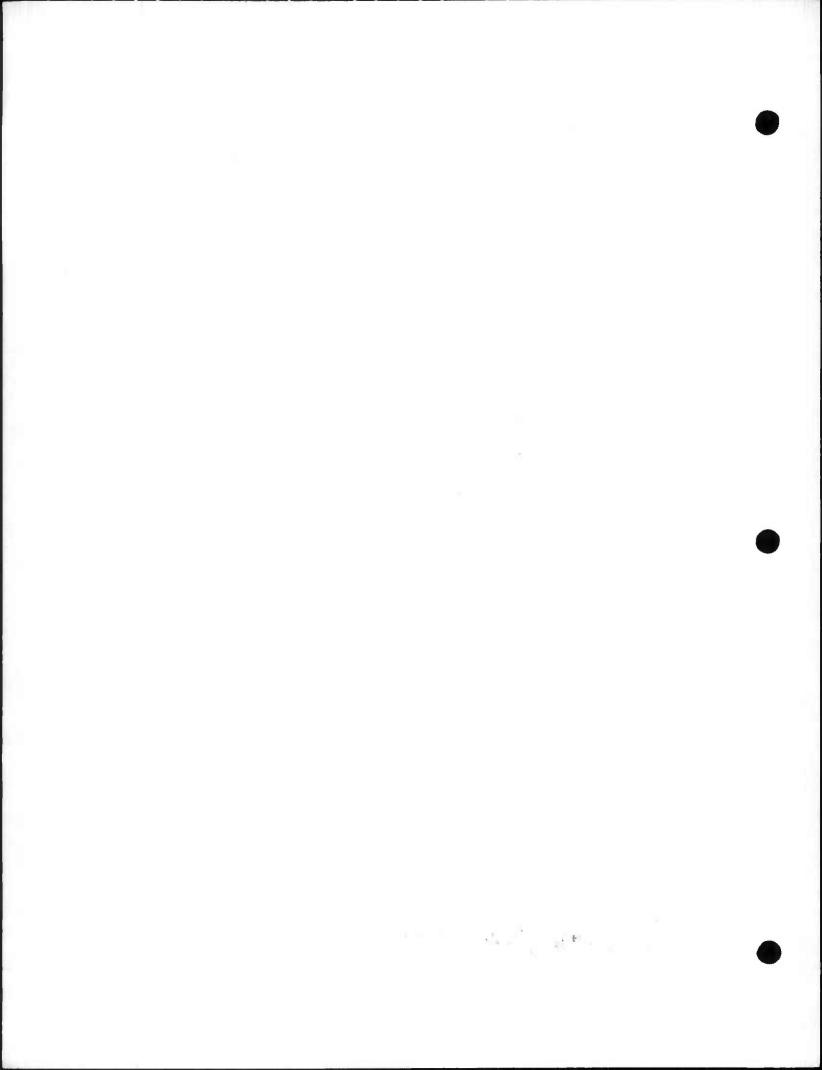
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31. DATE FILED (Month, Day, Year)

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MD



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Abours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans be filled within 72 hours after death with the State begin, of Health and Merial Hygiene prior to burial, cremation, or removal. IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - STATE REGISTRAR	STATE OF M		D / DEPAR CERTIF					MENT	AL HYGIEN REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last) THOMAS ROBET	RT (CASSID	Υ					MON	e of OEATH	4.0	95	3. TIME OF GEATH 1:45 A M
	214 56 8184	1 💢 M 2 🗆 F	6. AGE (In yr. 45	s. last birthday) YRS.	IF UNDER MONTHS	1 YEAR DAYS	IF UNDER	MIN.	(Mor	E OF BIRTN 1th, Day, Year) UARY 11		8. BIRTH Count	IPLACE (State or Foreign
TOR	90. FACILITY NAME (if not institution, give stre Fort Howard VA RESIDENCE OF DECEDENT		al Ce	nter	96. СПУ, FO1		HOWE		EATN	57	9c. COU	NTY OF D	
DIRECTOR	10e. STATE 10b. COUNTY Maryland Harf	ord			Y, TOWN O				-				10d, INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 59 Neptune Dri				OPPO	7	ZIP COD	-			10g. CIT	USA	WHAT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT FORCES? 12 IF YES, GIVE WI 1969 t	YES 2	□NO	l II	yee, sp	ecify Cubi	OF NISPAI in, Mexica Specif	in, Puerto	IN? (Specify Yes Ricen, etc.)	or No —	14. RACI	E — American Indian, k, White, etc.
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade or Elementary/Secondary (0-12)	TION ompleted) College (1-4 or 5 +)		Give kind of the Do NOT us	work done during most of working se retired.)				Balti			tv	
BE CON	17. FATNER'S NAME (First, Middle, Last) Francis C. Cas	sidy					Ма	ry	ME (First, Leh	Middle, Meiden ecka	Sumame)		
2	Mary Ann Cassi			59 N	ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) [eptune Dr. Joppa, Md. 21085]								
	20e. METHOD OR DISPOSITION 1		cemeters	ceand date	ther place)	tor	У	SS OF FA	7-:	10 Ba1		ore,	
	anthony	Colt	Con	mell	LL C	onn 110	ell So	y Fu 11e:	une: rs l	Point	Rd	2122	Oundalk 22
	23. PART I. Enter the diseases of conshock, or heart failure Li- IMMEDIATE CAUSE (Finel disease or condition resulting in death)	ANOXIC B	RAIN	line.	DUE							rest,	Approximate Interval Between Onset and Death 10/15/92
EHIICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								10/15/92				
MEDICAL C	PART II. Other significent conditions contributing to deeth but not resulting BILATERAL ULCERS OF THE HTPS									24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO		. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO CDMPLETIDN OF CAUSE OF DEATH?	
rutsician: n	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WINCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? WHOSPITAL: OTHER:												
or Phrs	1 YES 2 NO 27. MANNER OF DEATN Accident Investigation	NJURY y, Year) 1992	26b. TIM	E OF URY	28c. INJI WO			6 Other (Specify) 28d. DESCRIBE NOW INJURY OCCURED SUBJECT INGESTED BARBITURATES			ITURATES		
3	3 🕅 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, building, etc. (Specify)					street, fectory, office 28t. LOCATION (St City or Town, S				y or Town, State)	Street and Number or Rural Route Number, State) 59 NEPTUNE DRIVE		
COMPLE	A	AN: To the best of r	ny knowledge emination end	, death occurs	n, in my op	ne, date	end place	, end due	to the co	euse(e) end men le end place, en	ner es ata	ted. ne ceuse(e) end menner se stated.
2	296. SIGNATURE AND PIPE OF CERTIFIER)						45			29d. DATE SIGNED (Month, Day, Year)		
	DR. RAUL RIVERA, M.	D9600	NOR'I	H POIN		AD, I	Т. н	IOWAI	æ.	MARYLAN	D 21	052	
	31. DATE JUL (1995 Ju	22 at This the	个人	ill									

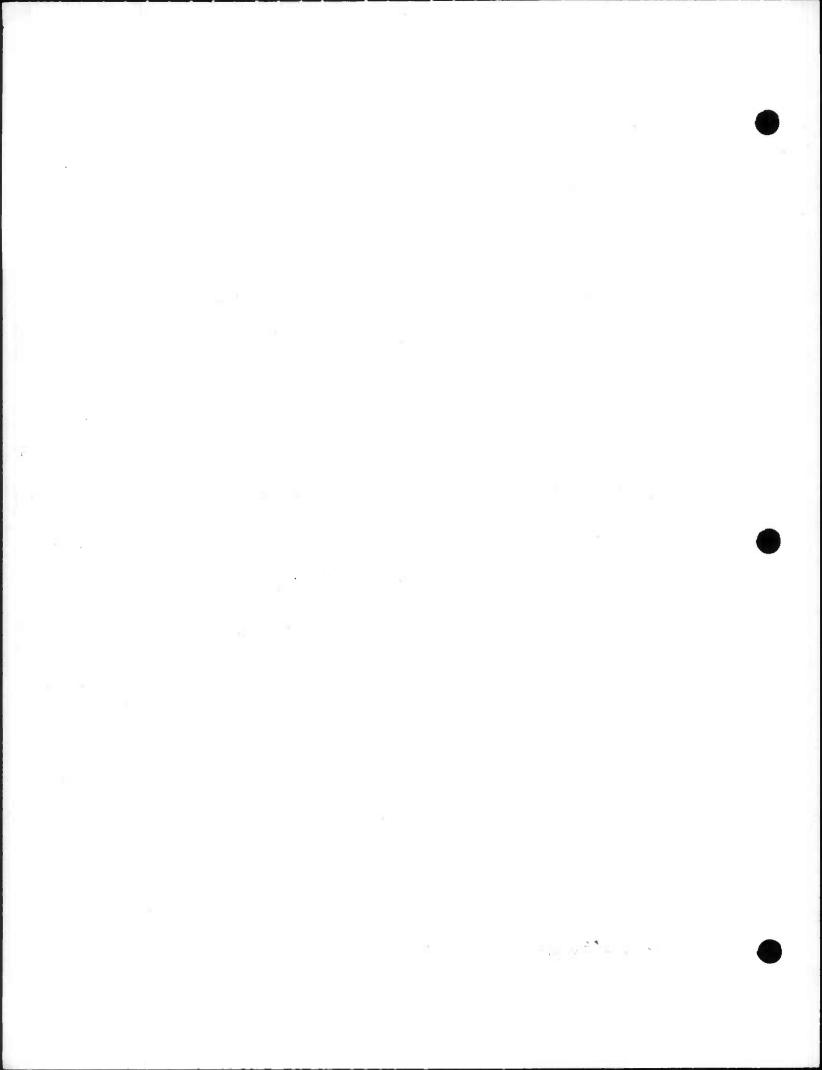
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BALTIMORE, MARYLAND 21215-	retained
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90	ritificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attends
D. BOX 68760	pecuted
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1	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)		CER	TIFICATE	OF D	EAIH	2. DATE OF DE			IME OF DEATH
- 1	George A	CUIFOG	-15his				MONTH	DAY	YEAR O	200
	4. SOCIAL SECURITY NUMBER	7	E (In yrs. last birth	day) IF UNDER		F UNDER 24 HRS.	7. DATE OF BIR	тн	6. BIRTHPLAC	E (State or Foreign
	135.24. 4228	1 M 2 F	6.4 Y	RS. MONTHS	DAYS HO	DURS MIN.	6/29/3	31	Country) New Je	rsey
_	9a. FACILITY NAME (If not institution, give			9b. CITY,	TOWN OR L	OCATION OF DE	ATH	9c. COUN	TY OF DEATH	
Ď.	THE JOHNS HO	PKINS HOSPI	TAL		BALT	IMORE C	ITY	N/A		
RECTOR	10a. STATE 10b. COUNT	Y	100	c. CITY, TOWN O	R LOCATION	1			10d.	INSIDE CITY
5	Maryland	N/A		В	altim	ore			1 🛚	LIMITS? YES 2 NO
M	10e. STREET AND NUMBER				101. ZII	P CODE		10g. CITIZ	EN OF WHAT	COUNTRY?
FUNERAL	2901 Boston St				2	1224		1	USA	
5	11. MARITAL STATUS 1 Never Married 2 XMarried	12. WAS DECEDENT EVER FORCES? 1 ☑ YE	S 2 NO				IC ORIGIN? (Spec		14. RACE A Black, Whi	merican Indian, Ita, etc.
Β¥	3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES		WWW	NO Specify			Specify; Whit	e
G	15. DECEDENT'S EDU		16a. DECEDE	NT'S USUAL OC	CUPATION		16b. KIND	OF BUSINESS/INDU		
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kir life. Do N	nd of work done of IOT use retired.)	luring most of	f working				
COMPLET		4	Civ	vil Eng	ineer			GSA		
8	17. FATHER'S NAME (First, Middle, Last)				16		ME (First, Middle, i			
BE	Starvros Culfogienis						essie Cl			
2	19a. INFORMANT'S NAME (Type/Print) Angeline V.	Culforionis						or Town, State, Zip		21224
			0b. PLACE AND D				_			
	26a METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Rem 4 Donation 6 Other (Specify)	noval from Stata	emetery cramator	v or other plecel				Owings 1		
_	23. PART I. Emer the diseases, or	complications that cause	ed the deeth.	Da 40	vid J 1 S.	Chester	Funera St. Ba	al Homes	, Mary	1and 21
	ahock, or heert failure. IMMEDIATE CAUSE (Final	B. DUE TO (OR AS	each line.			,				Interval Betwee
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUEN	CE OF):	neu	ysu				
EDICAL	PART II. Other algorithms condition		but not reaul	ling in the un	derlying ca	ause given in	P	WAS AN AUTOPSY PERFORMED? YES 2 100	COM OF D	E AUTOPSY FINDING LABLE PRIOR TO PLETION OF CAUSE DEATH? YES 2 PMO
	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH	YES N	10 🗆	UNCERTAIN	10		1	150 2 15 110
N.	25. WAS CASE REFERRED TO MEDICAL	HOSPITAL:	26. PLACE OF	DEATH (Check of						
			rtpatient 3 🗆 D	OA 4 Nura		Realdence	6 Other (Speci	fy)		
SICIAN:	EXAMINER? 1 PYES 2 PNO	1 ☑ Inpatient 2 ☐ ER/O			28c. INJURY		26d. DESCRIBE	HOW INJURY OCC	URED	
PHYSICIAN: N	EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH	26a. DATE OF INJUR (Month, Day, Year		INJURY	WORK?					
SICIAN:	EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	26a. DATE OF INJUR' (Month, Day, Year		INJURY M	WORK?	2 🗌 NO				
ED BY PHYSICIAN:	EXAMINER? 1 □ YES 2 □ NO 27. MANNER OF DEATH 1 □ Neturel S □ Pending	26a. DATE OF INJUR	RY — Al home, fi	INJURY M	WORK?		261. LOCATION ((Street and Number (or Rural Route i	Number,
MPLETED BY PHYSICIAN:	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29a. CERTIFIER (Check only)	26a. DATE OF INJUR (Month, Day, Year) 26a. PLACE OF INJUI	RY — Al home, fi	injury M	WORK? 1 VES Pry, offica	2 NO	City or Town	, State) nd manner as state	d.	
ETED BY PHYSICIAN:	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29a. CERTIFIER (Check only)	26a. DATE OF INJUR (Month, Day, Year) 26a. PLACE OF INJUI building, aic. (Sy ilCIAN: To the best of my knot ER: On the best of axaminat	RY — Al home, fi	injury M	WORK? 1 VES Ory, offica me, data and olinion, death	2 NO	to the cause(a) a	nd manner as state	d.	manner as stated

Johns (topkins (bypital)
32. REGISTRAR'S SIGNATURE

SEGIO TIM





TO BE COMPLETED BY FUNERAL DIRECTOR

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REGISTRAR	CER	TIFICATE OF DEATH		REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)	THE COL	LE	2. DATE MONTH	OF DEATH	3. TIME OF DEATH
216101 10.0	SEX 6. AGE (In yrs. last birt			of BIRTH 6. Day, Year 29	BIRTHPLACE (State or Foreign Opuntry)
EACHITY NAME (II hot institution, give street	end number) DITAL	BAH MA	0 -	9c. COUNTY	OF DEATH
10e. STATE / 10b. COUNTY	1	c. CON, TOWN, ON LOCATION	1000		
MARY AND NUMBER	<u> </u>	DAH more	2 ,	I management	10d. INSIDE CITY LINTS? 1 FYES 2 NO
2825 W. B	relvedere	we 212	211	U-	S HOUNTRY?
1 Martial States 1 Never Merried 2 Merried 3 Widowed 4 Divorced	P. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 THO IF YES, GIVE WAR OR DATES	If yes, specify Caban, I	IISPANIC ORIGIN Ilexicen, Puerto R Specify:	? (Specify Yes or No— 14 licen, etc.)	RACE — American Indian, Black, White, etc.
15. DECEDENT'S EDUCATE (Specify only highest grade com	ON 160. DECEDO	ENT'S USUAL OCCUPATION nd of work done during most of working	16b.	KIND OF BUSINESS/INDUS	TRY
	college (1-4 or 5+)	usewife		own Ho	mE
HERRY GEN	try	18. MOTHER	Cille	Bish Andre Syrama DIX ov	1
196. INFORMANT'S HAME (Type/Print)	THO 11 100. MA	ULING ADDRESS Street and Number or	Rural Rouge Numb	de Caryor Rowey James 224 Co	m 1.
GWERSOLYNC.	HAROLN !!	09 Homeste	Ad-	ST. DATTO	111021218
20s. METHOD OF DISPOSITION 1 Burlat 2 Condition 3 Removal 4 Donation 5 Other (Specify)	from State Adversary Comments	DATE OF DISPOSITION (Nume of	ark 1/	7 ARBUT	or Town, State
21. SIGNATURE OF UNERAL BERVICE LICENS	and one	MARS hA	mary	Ings JR	PH PA
23. PART I. Enter the diseases, or com	olications that caused the death.	Do not enter the mode of dying	, such as cerd	isc or respiratory errest	
IMMEDIATE CAUSE (Final disease or condition resulting in dasth)	and only one cause on each line.	insica			Onset and Death
	DUE TO OR AS A CONSEQUEN	ICE OF):		1 1.	170
Sequentially list conditions,	Meruselera	tic (gralo).	ascul	las dise	Be Urs
if any, isading to immediats	DUE TO (OR AS A CONSEQUEN	ĆE OF):			
CAUSE (Disease or injury					
that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUEN	ICE OF):			
d					
PART II. Other significant conditions co	ontributing to death but not result	ting in the underlying causs give	n in Part i.	24a. WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
				PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
				1 123 2 2 100	DF DEATH?
DID TOBACCO USE CONTRIB	UTE TO CAUSE OF DEATH	YES I NO II UNCER	TAIN 🗆		1 163 2,5 110
25. WAS CASE REFERRED TO MEDICAL		DEATH (Check only one)			
	OSPITAL: Inpatient 2 ER/Outpatient 3.600	OTHER:	ence 6 🗆 Other	(Specify)	
27. MANNER OF DEATH	28e. DATE OF INJURY 28	b. TIME OF 28c. INJURY AT		CRIBE HOW INJURY OCCUR	ED
1 Nstural 5 Pending 2 Accident Investigation	(Month, Day, Year)	M 1 YES 2 N	0		
3 Suicide 6 Could not be	28e. PLACE OF INJURY — At home, t	erm, street, tectory, office	281. LOCA	TION (Street end Number or I	Rural Route Number,
4 Homicide determined	building, atc. (Specify)		City o	r Town, State)	
290. CERTIFIER 1 CERTIFYING PHYSICIAN	To the best of my knowledge, death o	courred at the time, date and place, an	d due to the care	se(e) and manner as stated	
	in the basis of exemination and/or invest				puse(e) end manner se stated,
29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENS			GNED (Month, Day, Year)
Amoton M. MC	rap	7) 14	5503	1	0 195
38. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEATH (ITEM 27)	(Type, Pant)	D 11	100	
Ameter M M 31. DATE FILED (Month, Depaylers	lacen M.D 50	Depoinst	B 9/10	IND ald	17
JUL 1 0 1995 Aug	STEEDING PROPERTY.	V			

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STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH 02 1995 AR CARMELLO COCO JULY 8:50 P LOUIS 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 - F 81 216-03-9638 Sept. 20 191 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH J.H.H.BAYVIEW MEDICAL CENTER DIRECTOR BALTIMORE N/A RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Dundalk 1 TES AND NO permit. FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit o burial, cremation, or removal. 6210 Eastbourne Avenue 21222 United States Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Maxican, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married 1 TES 2XXNO BY 3 🔀 Widowed 4 🗌 Divorced Specify: Specify. White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRO (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) 5 Years Supervisor Shoe Factory 17. FATHER'S NAME (First, Middle, Last) 16, MOTHER'S NAME (First, Middle, Maiden Sumame) 76 BE Rosaroi Coco Marietta Bianca notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 Rose Johnson 2104 Parksley Avenue Baltimore, Maryland 21230 9 20a, METHOD OF DISPOSITION
142-Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — Cify or Town, Stata DATE must Sacred Ht. 06 Mary Cem. 7/5/95 4 ☐ Donation 5 ☐ Other (Specify) Dundalk. Maryland examiner 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE hours after death. 7922 Wise Ave. Dundalk, MD 21222 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximats ahock, or haert failure. List only one cause on each line. interval Between 6 **IMMEDIATE CAUSE (Final** Onset and Death the disease or condition Hypertensive Arteriosclerotic Cardiovascular Disease resulting in death) traumatic event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): the attending physician a Mental Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING other t CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? PHYSICIAN: MEDICAL Health and N C.O.P.D., CHRONIC RENAL DISEASE, DIABETES 1 TYES 2 NO OF DEATH? YES 2 NO been s DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has by ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h HOSPITAL: OTHER: 1 X YES 2 NO 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 9 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT WORK? marked, 26d. DESCRIBE HOW INJURY OCCURED 1 XNatural 5 Pending м 1 YES 2 NO DIRECTOR: After the hours after death v BY Investigation 2 Accident 26s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 28 R 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. FUNERAL within 72 h HOSPITAL TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: I 2 MEDICAL EXAMINER: On tion end/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. RE AND TITLE OF CHE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE JUNE 03,1995 O.C.M.E. 2 PLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 ocke Mortin, Day

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

DHMH-16 Rev 1/89

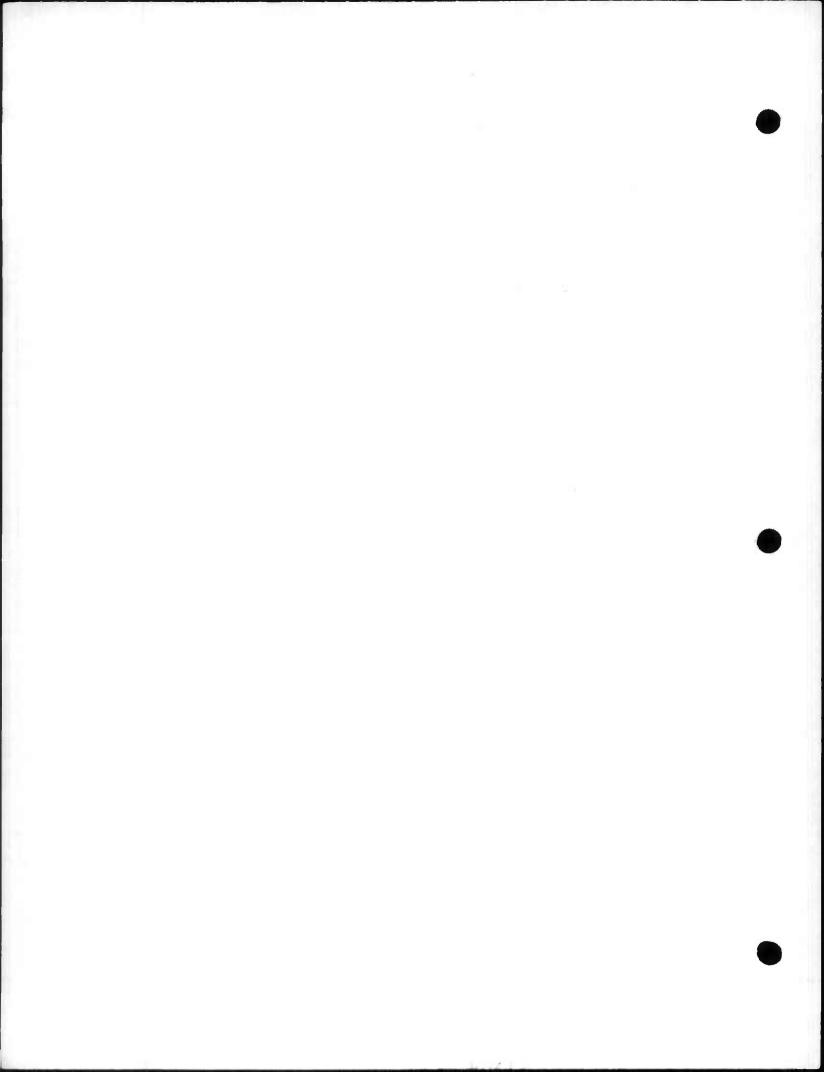
BALTIMORE, MARYLAND 21215-0020	r death. Page 6 may be retained by the hospital or attending physici	to frenched discussion where R should be detected to
	1 24 hours after	he filled in her of
DIVISION OF VITAL RECORDS, P.O. BOX 68760	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicia	DIRECTOR After this certificate has been signed by the strength of the formulately filled in his the tomoral discount of the strength of the formulation and committee of the formulation and the formulation and the formulation of the formulat
DIVISIO	L OR ATTENC	NIBERTOR.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 35 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTM	ENT OF I	REALTH AND	MENTAL HYGIE						
	1. DECEDENT'S NAME (First, Middle, Last)		DEMINI	2. DATE OF DEATH	3. TIME OF DEATH	1						
	VIVIAN C	RAWFORD				JULY	3	95	7:25	PM		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs.		MDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		8. BIRTH	PLACE (State or For	elgn		
	216-30-8666	1 □ M 2 🏋 F 6]	YRS.	THE DAYS	HOURS MIN.	February	14,34	Mar	vland			
	9a. FACILITY NAME (If not institution, give st	reet and number)	9b.	CITY, TOWN	OR LOCATION OF E			NTY OF D				
9	Levendale Nursing	Home	p.E	Balti	imore							
EG	10a. STATE 10b. COUNTY	RESIDENCE OF DECEDENT										
E	Maryland				IION				10d. INSIDE CITY LIMITS? 1 YES 2 N			
ור	Maryland Baltimore 1 100. STREET AND NUMBER 1001. ZIP CODE 1009. CITIZEN OF WHA 2434 W. Belevdere Ave. 21239 U.S.											
FUNERAL DIRECTOR												
S	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S.	ARMED	13. WAS DEC		ANIC ORIGIN? (Specify	fea or No		- American Indian			
BY F	1 Never Married 2 Married	FORCES? 1 YES 2 F IF YES, GIVE WAR OR DATES	Пио	If yes, sp	ecify Cuban, Mexic	can, Puerto Rican, etc.)		Black Specif	White, etc.	"		
	3 Widowed 4 Divorced							ороси	white			
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of	completed)	Give kind of work	fone during mo	ON ast of working	16b. KIND OF E	USINESS/INC	DUSTRY				
7	Elementary/Secondary (0-12)	College (1-4 or 5+)	ife. Do NOT use reti									
ME	17. FATHER'S NAME (First, Middle, Last)		Homema	ker								
	Harry Clifton Hite				11-2	AME (First, Middle, Maid						
H	19a. INFORMANT'S NAME (Type/Print)		10h HAII ING ADD	DE00 (0)		dred Kath]						
2	Carol Olszynski								1011			
	20a. METHOD OF DISPOSITION	20h PLAC	EAND DATE OF DIS			t, Baltimo	OCATION -		1211			
	1 Buriel 2 Cremetion 3 Remo		crematory or other p		irrid Ur	DATE	OCATION —	City or low	vn, State			
	21. SIGNATURE OF FUNERAL SERVICE LICE	MANUEROnald Wade.	Dir.	22. NAME AI	D ADDRESS OF F	ACILITY State	Anato	mrz D	and			
	North 1	1/1/20		655 W.	Baltima	ore ST., E	alto	my Do	21201	- 1		
-	23. PART I. Enter the diseases, of co	condications that caused the										
	SHOCK, OF HEST THIUTE. L	ist only one ceuse on each ile	ne.	nter the mo	da of dying, su	ch as cardiac or rea	piratory sr	rest,	Approximat interval Bet			
	IMMÉDIATE CAUSE (Finel disease or condition → PNEUMONIA (RECURRENT)									Death		
	reaulting in death)	DUE TO (OR AS A CONS	EQUENCE OF:	7 (VC CI	NRKEN	1/_		WK.	2		
_				ED	JE1 00	ATHIN			mos	.		
9	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): MOS											
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury	CORONAR	LY AR	TERY	Disc	ASP			YRS			
E	that initiated events	DUE TO (OR AS A CONS						-				
E	resulting in death) LAST											
	PART II. Other significent conditions	contributing to death but not	requiting in th	underhin	Cause oliver le	Post I as uno	N AUTOPSY	Lan		1		
CAL		,	Tooland III th	o uncorrying	J cause given in	PERF	ORMED?		WERE AUTOPSY FINE AVAILABLE PRIOR TO COMPLETION OF CA			
						1 [YES	2 NO		OF DEATH?			
Σ	DID TOBACCO USE CONTR	IRLITE TO CALICE OF DE	ATU VEC F	7 NO E	UNCERTAI	N. 1020			1 TYES 2 NO	,		
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL		ACE OF DEATH (C)		UNCERIAI	N LX						
Sic		HOSPITAL: 1 Cinpatient 2 ER/Outpatient	ОТ	HER:		6 Other (Specify)						
Ŧ	27. MANNER OF DEATN	28s. DATE OF INJURY	28b. TIME OF	28c, INJ	URY AT	28d. DESCRIBE NOW	INJURY OCC	CURED		-		
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	YRULNI		RK? 'ES 2 NO					- 1		
	3 Suicide 6 Could not be	28e. PLACE OF INJURY — At I building, etc. (Specify)	home, farm, street,	factory, office		281. LOCATION (Street		or Rural Ro	oute Number,	\dashv		
2	4 Nomicide determined	January, stat (opcony)				City or Town, Stat	0)					
COMPLETED	29a. CERTIFIER (Check only 1 CERTIFYING PHYSIC	IAN: To the best of my knowledge,	death occurred at 1	he time, data	and place, and du	to the cause(a) and m	enner as stat	ed.		\neg		
MO		: On the basis of examination and/o							and manner as stat	led.		
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU				Month, Day, Year)			
BE	marken 24	Mabrusa	10		D45		D.T.	L/A	3 190	1		
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF PEATN (IT	EM 27) (Type, Print)		- 10	, – /	40)	7	- / /			
	A . A	NAZNEY	2434	W.	BELVE	DERE	BAC	Th	MD 2/3	2/5		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE				, ,,,,,,	200	10	A. da.	-		
	POL T 0 1992	- Con Rand	all									



TO BE COMPLETED BY FUNERAL DIRECTOR

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within afours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

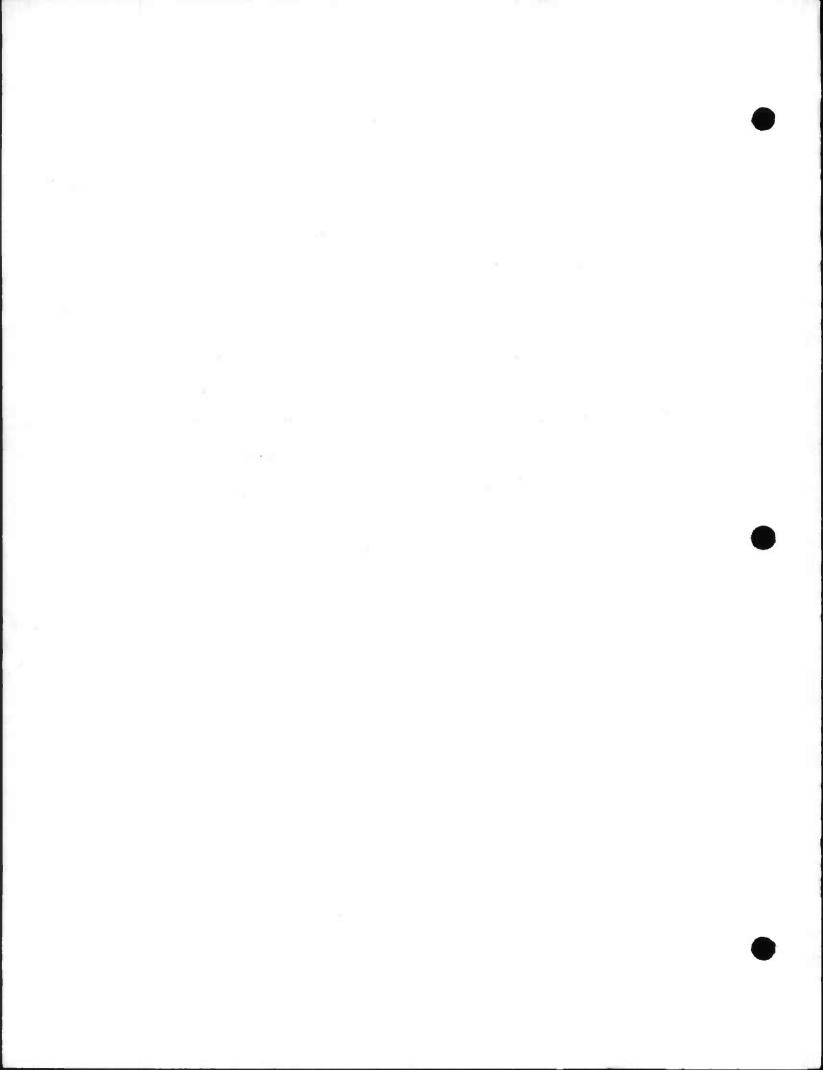
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

JUL 1 0

FOR 1 - STATE REGISTRAR	STATE OF A			MENT OF H	EALTH AND		YGIENE EG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)	V.		LLAH			2. DATE OF E	DEATH	YEAR 95	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER 432-10-9349	5. SEX 1 🔀 M 2 🗌 F	8. AGE (In yrs. Ia		UNDER 1 YEAR HITHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF B (Month, Day JAN . 26	HRTH y, Year)	8. BIRTHP Country	SISSIPPI
96. FACILITY NAME (If not institution, give of CHARLESTOWN CARE			91		SVILLE	EATH	9c. COU	BALT	TIMORE
10a. STATE 10b. COUNT	ALTIMORE	-		OWN OR LOCA ONSVILI					10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO
719 MAIDEN CHOICE	- #401			10	ZIP CODE	28	-	S.A.	HAT COUNTRY?
11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2	RMED NO	If yes, sp	ecify Cuban, Maxic 2 NO Speci	an, Puarto Rican	pecify Yas or No—	14. RACE Black, Specify	— American Indien, White, etc.
15. DECEDENT'S EDU (Specify only highest grack Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5 + 4 YRS) (0	Give kind of work b. Do NOT use re		st of working		O OF BUSINESS/IND		7A)
17. FATHER'S NAME (First, Middle, Last) JAMES Y. DOLLAHIT	E					AME (First, Middle	e, Maiden Surname)		
190. INFORMANT'S NAME (Type/Print) EVELYN F. DOLLAHI	TE	15					ity or Town, State, Zip		E,MD 21228
20e METHOD OF DISPOSITION 1 \(\tilde{\Omega} \) Burial 2 \(\tilde{\Omega} \) Cremation 3 \(\tilde{\Omega} \) Rem 4 \(\tilde{\Omega} \) Donation 5 \(\tilde{\Omega} \) Other (Specify)		206. PLACE cometery. cri ARLING	ANDDATEOF	ISPOSITION (NA		DATE	20c. LOCATION -	City or Tow	n, Stata
21. SIGNATURE OF FUNERAL SERVICE LI	Plot	amar	,	HUBBA	RD FUNER WILKENS	MOH LAS	E, INC.	e M	D 21220
23. PART I. Enter the diseases, Dr. ehock, or heert fellure. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth)	List only one ceu	se on each line	е.	enter the mo	andre	ch as cerdiec	or respiratory arr	est,	Approximate Interval Batween Onset and Death
Sequentielly liet conditions, if sny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in death) LAST	с	(OR AS A CONSE							
PART II. Other significent condition	s contributing to	deeth but not	resulting in t	he underlyin	g ceuse given in		WAS AN AUTOPSY PERFORMED? YES 2 NO		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CA		ATH YES		UNCERTAI	N 🗆			1 VES 2 NO
EXAMINER?	HOSPITAL:	ER/Outpatient	Q	THER:	e 5 🗆 Reeldence	6 Other (Spe	ecity)		
27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	26a. DATE OF (Month, Da	ay, Year)	28b. TIME O	M 1	RK? YES 2 NO	28d. DEŞCRIE	E HOW INJURY OCC	CURED	
3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE Of building,	FINJURY — At ho etc. (Specify)	ome, farm, stree	et, factory, offic		26f. LOCATION City or Tox	N (Street end Number vn, State)	or Rural Ro	ute Number,
29e. CERTIFIER (Check only one) 1 CERTIFYING PHYS									end menner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIE	- hylo	~~			29c. LICENSE NU DZ6	MBER 5 473	29d. DATI	E SIGNED	Month, Day, Year)
BERNARD F	COMPLETED CAUS	SE OF DEATH (ITE	M 27) (Type, Pri	7/1	MAID	EN (HOLLE	= //	25515.A

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	1 - FOR STATE REGISTRAR	STATE OF N	MARYLA	ND / DEPAR	RTMENT OF	HEALTH AND	MENT	AL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Lest, I.@ONA	L.	L. Evans						995 YEAR		3. TIME OF DEATH 5:45P
	4. SOCIAL SECURITY NUMBER 218-28-6991	5. SEX		yrs. last birthday) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS		(Mor	7. DATE OF BIRTH (Month, Day, Year) 12–22–31			PLACE (State or Foreign Y)
TOR	9a. FACILITY NAME (If not institution, give 8017 Edgewater	ter Ave. Baltimore Baltir									
DIRECTOR	10a. STATE 10b. COUNTY	Baltimore	9	10c. Cf7	y, town or Loc Baltim						10d. INSIDE CITY LIMITS? 1 YES 2 X NO
FUNERAL	106. STREET AND NUMBER 8017 Edgewater	water Ave. 101. ZIP CODE 21237 109. CIT									VHAT COUNTRY?
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES	2 NO	If yes,		Ican, Puerto Rican, etc.)			14. RACE Black Specif	- American Indian, t, White, etc.
ETED.	15. DECEDENT'S ED (Specify only highest grad			18a. DECEDENT'S (Give kind of life. Do NOT u	work done during .	TION most of working	16	b. KIND OF BUS	SINESS/INDL	STRY	
COMPLE	Elementary/Secondary (0-12)	College (1-4 or 5 d	+)		ims Cle	rk		Commen	ccial	Cre	dit
BE CO	17. FATHER'S NAME (First, Middle, Lest) Raymond Warti	nen				18. MOTHER'S N	an R	Middle, Maiden Extoth	Surname)		
TO B	19a. INFORMANT'S NAME (Type/Print) NORMAN C. Evan	າຣ		196. MAJLING 801	ADDRESS (Street	ater Ave.	Bal	nber City or Tow timore,	n, State, Zip (212	37
	20a. METHOD OF DISPOSITION 1 M Burlet 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) State 20b. PLACE AND DATE Of DISPOSITION (Name of Complete, Caemetory or other place) Complete, Caemetory or other place) Calcients Or Faith 7-10-95 Baltimore, MD										
8	21. SIGNATURE OF ELIVERAL SERVICE LICENSIA 22. NAME AND ADDRESS OF FACILITY CVach/Rosedale funeral home 1211 Chesaco Ave.										
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart fellure. List only one ceuse on sech line. iMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OR):										Approximate interval Batwee Onset and Deat
RTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF):										
MEDICAL CE	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 24s. WAS AN AUTOPSY PERCOMEN?										WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
N: ME	DID TOBACCO USE CONT	TRIBUTE TO CA	USE OF	DEATH YE	S NO	UNCERTA	IN 🗆				1 TYES 2 NO
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:		B. PLACE OF DEA	OTHER:	V	8 □ Oth	er (Specify)			
ву РНУ	27. MANNER OF DEATH 1 Vetural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Dey, Year) 28b. TIME OF INJURY AT WORK? 28c. INJURY AT WORK?									-
ETED 8	2 Accident 3 Suicide 8 Could not be determined 28a. PLACE OF INJURY — At home, tarm, street, factory, offica building, atc. (Specify) 28a. PLACE OF INJURY — At home, tarm, street, factory, offica City or Town, Steete										oute Number,
COMPLE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of example										
O BE CO	296. SIGNATURE AND TITLE OF CONSISTE		1		,	DAL LICENSE NU)			(Montyl, Day, Year)

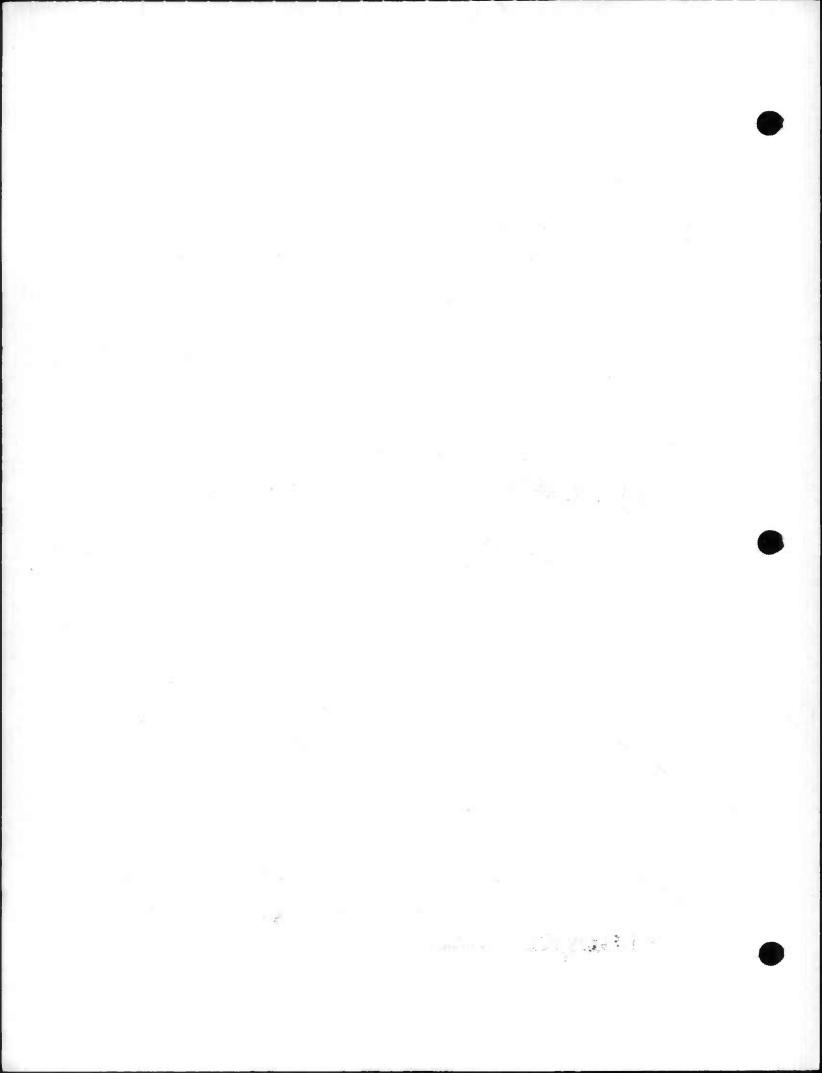
COMPLETED CAUSE OF DEATH (ITEM 27) (Type, POINT)

RBACH 9000 PRONKIN

32. REGISTRAD'S SIGNATURE AND AUGUST RENDELL

TO THE HOSPITA TO THE FUNERAL DE filed within 72 IMPORTANT: If

DHMH-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020	inficate be executed within and hours after death. Page 6 may be retained by the hospital or attending physician.	physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
	Ĕ	filled
. BOX 68760	ficate be executed within	physician and completely filled in by the

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with ear hours after death, Page 6 may be retained	HE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 shoult	cremat
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30. NAME AND ADDRESS OF PERSON

31. DATE FILED (MORITI, Day, 1901)
JUL 1 0 1995

O COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

OMOURA

2. REGISTRAR'S SIGNATURE

	REGISTRAR 1. OECEDENT'S NAME (First, Middle, L Alma H	Everhart			AIL OI	DEATH	REG. NO. 2. DATE OF DEATH JULY 9. 13	995	YEAR 3.	TIME OF CEATH 3:53 p.
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. I	est birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS.	July 9, 13		a BIRTHPL	ACE (State or Foreign
	217-32-9306	1 🗆 M 2 💢 F	70		ONTHS DAYS	HOURS MIN.	(Month, Dey, Year) Mar. 25,1	-	Country) Mary	
	9s. FACILITY NAME (If not institution, g			9	b. CITY, TOWN	9c. COUN	COUNTY OF DEATH			
10 10	Longview Nursi					lancheste	r	C	arrol	1
DIRECTOR	10a. SYATE 10b. CO	UNTY		10c. CITY, T	TOWN OR LOCA	NTION			10	d. INSIDE CITY
8	Md.	Carroll			Manche	ster			1	LIMITS?
FUNERAL	10a. STREET AND NUMBER	Essel on Dd			10	21102		10g. CITIZ		T COUNTRY?
W.	2/10 Bert	Fowler Rd.	EVER IN ILE	PMED	I so was no				U.S.	
BY FU	1 Never Merried 24 Married 3 Widowed 4 Divorced	FORCES? 1 [YES 2	CNO	If yes, s	pecify Cuben, Mexica S 2 NO Specif	NIC ORIGIN? (Specify Yes in, Puerto Rican, etc.) y:	or No	Black, W Specify:	American Indian, thite, etc.
	15. DECEDENT'S	EDUCATION	16a. E	ECEDENT'S US	UAL OCCUPAT	ION	16b. KIND OF BUS	INESS/INDU	JSTRY	11112100
	(Specify only highest of Elementary/Secondery (0-12)	College (1-4 or 5+)	- 1	Give kind of world te. Do NOT use n	k done during m etired.)	iost of working				
COMPLET	Elementary/Secondary (0-12)		Pi	nysics	Lab. 1	nspecter	Johns Ho	оркіл	s uni	versity
	17. FATHER'S NAME (First, Middle, Last Cleveland						ME (First, Middle, Maiden : Goldsmith	Sumame)		
	19e. INFORMANT'S NAME (Type/Print)	naruesty	Ι,	OF MAILING AD	ODSESS /Street		Route Number, City or Town	Ctute 7in	Codel	
TO B	Horner B. Ever	nart		2718 Be	ert Fow	ler Rd.,	Mancheste	r, Md	211	.02
	20a. METHOD OF OISPOSITION 1 W Burial 2 Cremetion 3 3 4 Donation 5 Other (Specify)	Removal from State	20b. PLACI	EAND DATE OF I	DISPOSITION (A	lame of	DATE 20c. LOC	CATION — C	Oity or Town,	State 11s. Md
	21. SIGNATURE OF FUNERAL SERVICE	E LICENSEE	LICAL J.	LOIIU Y				VII.2.1		
	1 11 11	1 11 N				* * **	CILITY			
	1 -20000	Eller					ral Chapel	oct on	Ma	21162
	23. PART I. Enter the diseases,	or complications that of	caused the	deeth. Do not	3296	Charmil	Dr., Manch			21102 Approximate
	23. PART I. Enter the diseases, shock, or heart fells	or complications that cure. List only one ceuse	caused the consect line	deeth. Do not	3296	Charmil	Dr., Manch			Approximate interval Batw
	shock, or heart fells	a	on each lir	Jtro	3296	Charmil	Dr., Manch			Approximate interval Batw
	shock, or heart fells IMMEDIATE CAUSE (Finel disease or condition	a	caused the consect line	Jtro	3296	Charmil	Dr., Manch			Approximate interval Batwo
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		1 - STATE REGISTRAR	STATE OF MARY	LAND / CE	DEPAR	RTMENT	OF H	IEALTH AND	MENT	AL HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Last) BETTY				EI	RNE	ST	MOI			EAR	3:15 PM
D			1 M 2 XF	E (In yrs. last		IF UNDER		IF UNDER 24 HRS HOURS MIN	(Mo	TE OF BIRTH onth, Day, Year)	25	BIRTHP Country)	LACE (State or Foreign
2. 3 should	СТОВ	98. FACILITY NAME (If not institution, give street 201 N.BROADWAY RESIDENCE OF DECEMENT	APT 17H					MORE C	DEATH		9c. COUNT	Y OF DE	ATH
it. Pages 1.	DIREC	10a. STATE 10b. COUNTY Maryland				Y, TOWN OF		TION				- 1	IOd. INSIDE CITY LIMITS? I YES 2 NO
in. ansit permit.	VERAL	201 N. Broadway	Apt. 17-H				101	ZIP CODE	31		10g. CITIZE	N OF WI	IAT COUNTRY?
215-0020 attending physician. se as the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	I2. WAS OECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2 NO	IEO O	11	yes, sp	ENDENT OF HISI ecity Cuban, Max 2 NO Spe	Ican, Puert	ilN? (Specify Ye o Rican, etc.)	e or No —	Black, Specify	- American Indian, White, alc. White
21 for u	PLETED	15. DECEDENT'S EDUCA (Specify only highest grade co Elementery/Secondary (0-12)	TION impleted) College (1-4 or 5+)	(Givi	e kind of I	USUAL OC work done do se retired.)	CUPATIO uring mo	ON ast of working	1	Sb. KIND OF BU	SINESS/INDUS	TRY	
A se s	SE COMPL	17. FATHER'S NAME (First, Middle, Last)						18, MOTHER'S	NAME (First	, Middle, Maiden	Sumame)		
TE, MARYL ay be retained by the page 5 should be to notified at	TO B	19a. INFORMANT'S NAME (Type/Print)		19b.	MAILING	ADDRESS	(Street a	nd Number or Rui	al Route Nu	mber, City or Tox	rn, State, Zip C	ode)	
e 6 m ector.		20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removi 4 Donetion 5 Other (Specify) In 21. SIGNATURE OF FUNERAL SERVICE LICEN	state	emetary, crem	atory or o	ther place)					CATION — CH		
death. tuner		Sumant 10	Chase			Ва	1ti	more St	., BA	Alto.,	MD 212	201	ard 655 W.
within 24 hou npletely filled I cremation, or vent, the m		23. PART I. Enter the diseases, or conshock, or heart fellure. List MMEDIATE CAUSE (Final disease or condition resulting in death)	pplications that cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause of the c	asch lina.	n	S						t,	Approximate interval Between Onset and Death
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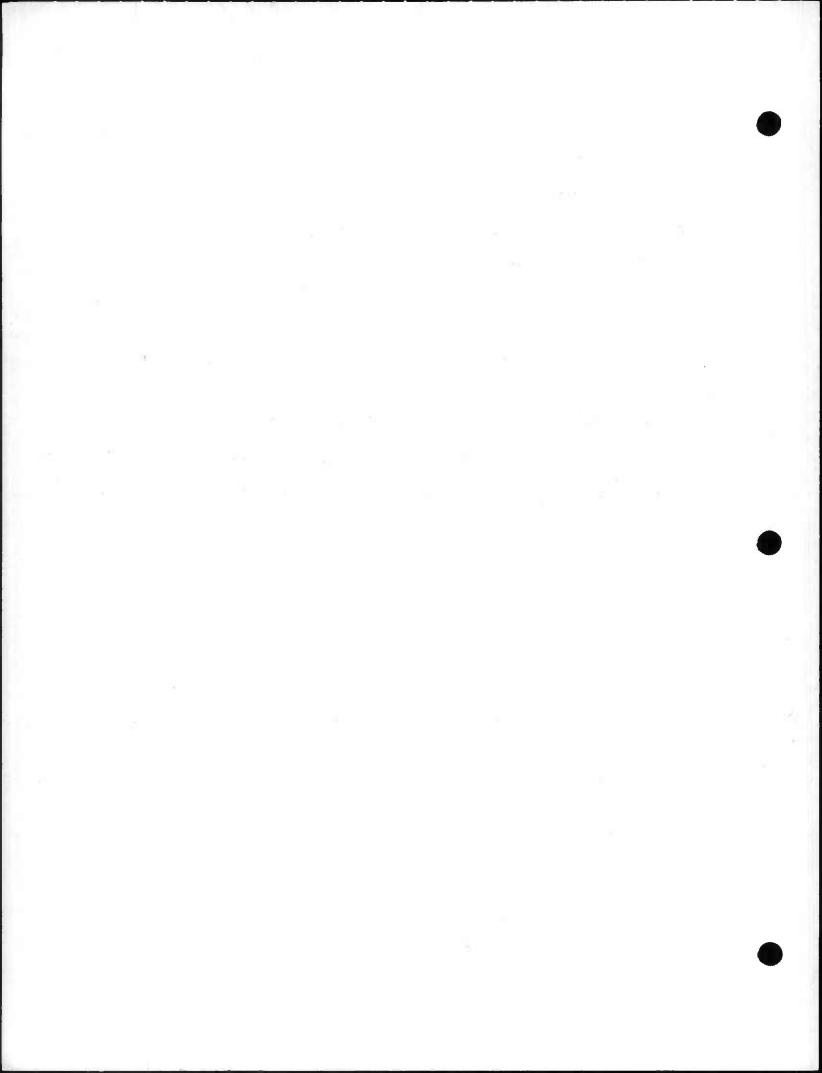
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BALTIMORE, MARYLAND 21215-0020	he death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should Marial Aurilana pages to burial companion or pages 1, 2, 3 should
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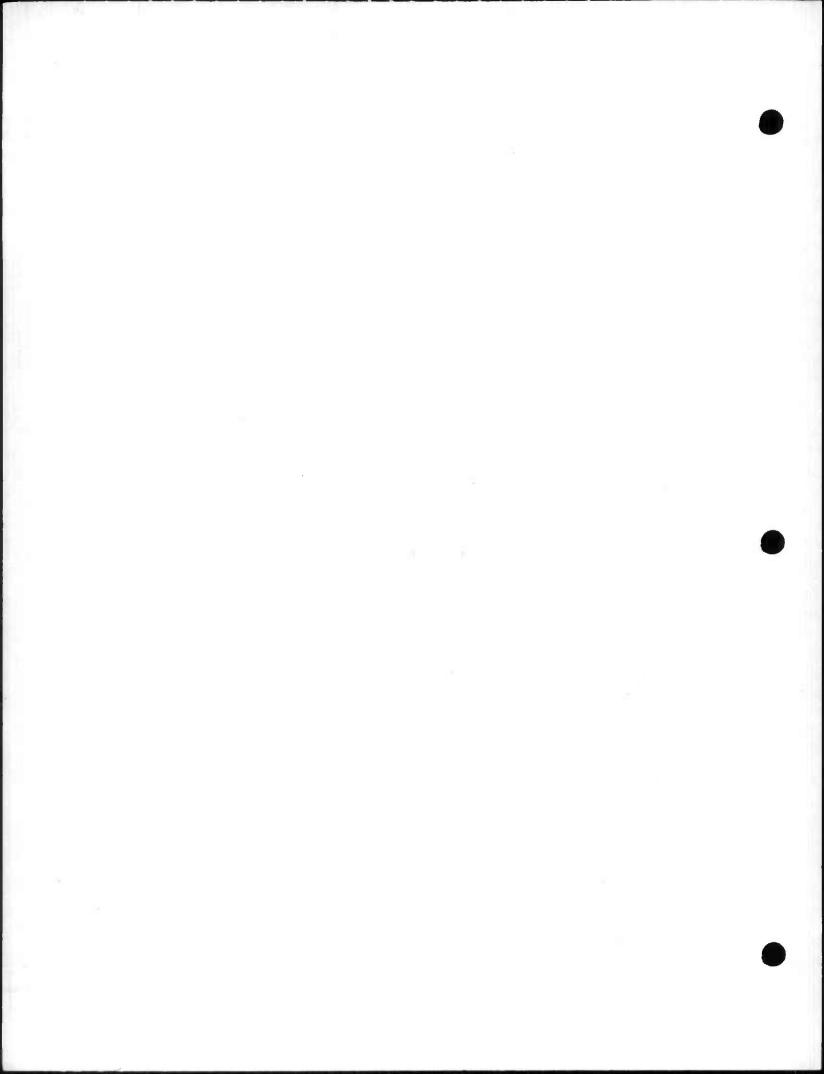
FOR 1 - STATE REGISTRAR	STATE OF				HEALTH AND	MENT					
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12th	N.A.	E	Barten	der			Ban	d Boz	<		
17. FATHER'S NAME (First, Middle, L.	nst)				18. MOTHER'S N		Middle, Maiden	Surname)			
William	Mar	lev			Hatti	6		Gri	ram		
19a, INFORMANT'S NAME (Type/Prin	•		19b. MAILING A	DDRESS (Street	and Number or Rural	Route Nui	mber, City or Tow	n, State, Zip	Code)		
Frank Ferr	ari		2018	Kelbou	ırne Ro	. B	altimo	ore,	Md.	2123	7
20a. METHOD OF DISPOSITION 1 Se Burial 2 Cremation 3	Removal from State		CE AND DATE OF	DISPOSITION (N	eme of			CATION — C			
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21. SIGNATURE OF FUNERAL SERV	ICE LICENSEE	1		22. NAME A	ND ADDRESS OF F	ACILITY					
1 V/Ulast	1//		-	JOSEI	PH N. Z	ANN	INO JI	R. FU	JNEF	RAL HO	ME
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IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions in the condition of	DUE 1 c. DUE 1 d. DUE 1	OF INJURY — At g, etc. (Specify)	SEQUENCE OF): SEQUENCE OF): SEQUENCE OF): SEQUENCE OF): ACE OF DEATH 29b. TIME 29b. TIME 20r Investigation, TEM 27) (Type, Pr	the underlyin (Check only one) THER: Nursing Hon Nursing Hon 28c. IN. W 1 at the time, deta in my opinion, of	g ceuse given in UNCERTAI DESTRUCTORY TO SERVICE T	Part I. 8 Oth 281. LO	24a. WAS AN PERFOR 1 VES 2 Ver (Specify) ESCRIBE HOW I	AUTOPSY MMEO? NJURY OCCI and Number of the data to the last the l	24b. 24b. URED or Rural Ri cause(a)	Approxininterval interval interval interval interval interval interval in the constant interval in the constant interval	nate Satwe S



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle,	Foxwell				2. DATE OF DEATH	DAY Y	3. TIME OF DEATH 95 03:15 Pm	
	4. SOCIAL SECURITY NUMBER 212-05-4044	1530ME2□F 8	(In yrs. last birthday) 7 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) January 1	2 1908	BIRTHPLACE (State or Foreign Country) Maryland	
CTOR	9a. FACILITY NAME (If not institution, Howard County RESIDENCE OF DECEDEN	General Hospit	al	Colum	nbia	ATH	96. COUNTY OF DEATH HOWard County		
DIRE	10a. STATE 10b. C	oward County	10c. CfT	CITY, TOWN OR LOCATION Ellicott City				10d. INSIDE CITY LIMITS? XXXXX 1 YES 2 NO	
VERAL	100. STREET AND NUMBER 2909 Ramblewood	l Road	-				USA	N OF WHAT COUNTRY?	
BY FUNER	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES	2-1 NO	13. WAS DEC	Black, White, atc. Specify: White				
COMPLETED	15. DECEDENT'S (Specify only highest Elamentary/Secondary (0-12) 1 2	grade completed) College (1-4 or 5+)	life. Do NOT us	rork done durina ma	st of working tor		Compa		
BE	17. FATHER'S NAME (First, Middle, Let John Leven Fox	well			Susan	ME (First, Middle, Melder E. Hindm	an		
5	Ms. LaRue Foxwer	ell Poyer	15501	Frederi	.ck Road,		, Mary	land 21797	
	1 Burlel 27 Cremation 3 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNETAL PRVI	Removal from State	MO0535	asnington 22. NAMEN	Cramatory Appress of FAC	6-29-95 ral Home, ity, Mary	P.A.		
CERTIFICATION	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr Injury that Initiated events resulting in death) LAST	DUE TO (OR AS A	A CONSEQUENCE OF):	oleed			Interval Between Onset and Death 2 days	
N: MEDICAL	Parxinso	GLSTIVE NOWTH	failur	e, Alzl	neimers,	PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
HYSICIAN:	25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 YES 2 NO	HOSPITAL:	26. PLACE OF DEAT	OTHER:	e 5 🗆 Rasidence	B Other (Specify)			
ву РНУ	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investiga	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. INJ		28d. DESCRIBE HOW	INJURY OCCUR	ED	
9	3 Suicide 6 Could no 4 Homicide datarmin	28a. PLACE OF INJURY building, etc. (Spec	— At home, farm, at cify)	treet, factory, office	`	281. LOCATION (Street City or Town, State)		Rural Route Number,	
COMPLET		PHYSICIAN: To the best of my know AMINER: On the basis of axamination						ause(a) and manner as stated.	
TO BE C	296. SIGNATURE AND TITLE OF CER	selle mo		29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 34613 Dune 28, 199					
	Steven Geller	MD 9501 000	Annapo	Prim) lis Rd	EZLI'cott	City M	0 21	042	
	JUL 1 0 1995	MEGISTRAR'S SIGN	ATURE:			,			



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withher hours after death. Page 6 may be retained by the hospital or attending physician.

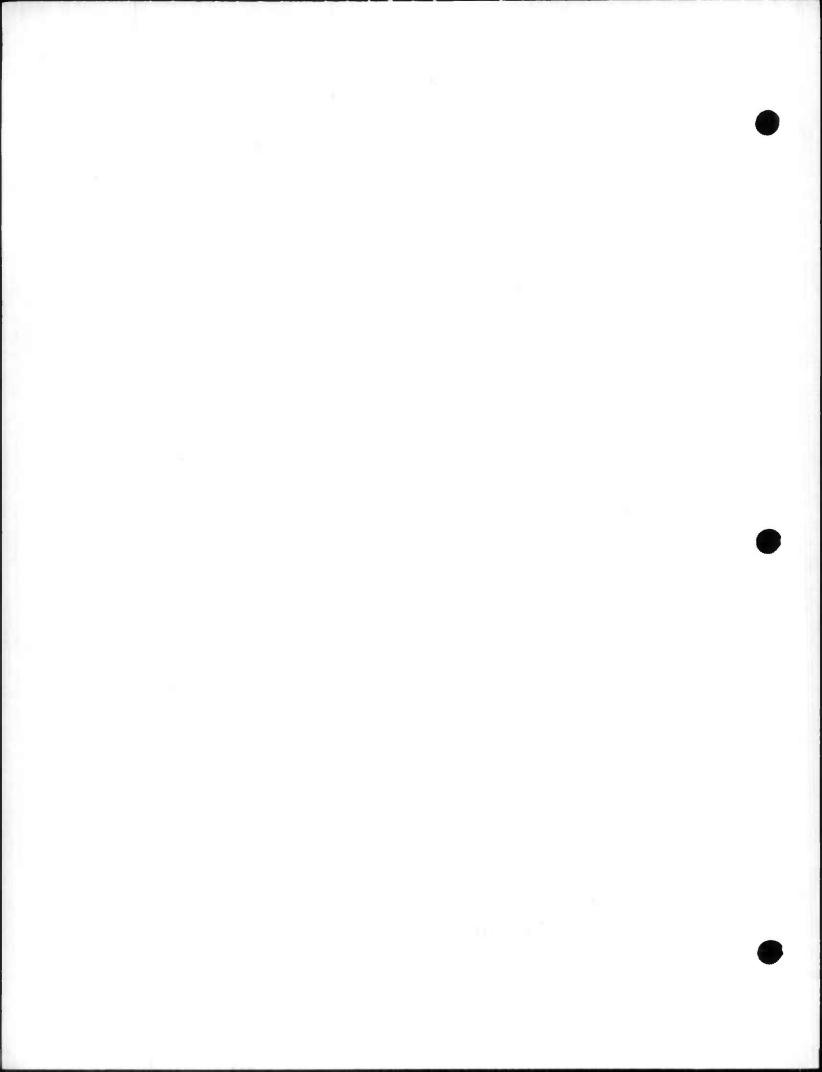
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF	DEATH			3. TIME OF DEATH
	IFANIA GEDI	EON								July	5		YEAR 1995	10:16 A M
	4. SOCIAL SECURITY NUMBER	BER	5, SEX	6. AGE (In yn	s. last birthday)	IF UNDE	t YEAR	IF UNDER	R 24 HRS.	7. DATE OF	BIRTH			PLACE (State or Foreign
	086-52-509	7	1 □ M 2 🂢 F	84	YAS.	MONTHS	DAYS	HOURS	MIN.	Dec.		1910	Country	"Haiti
	9e. FACILITY NAME (If not in	stitution, give	street and number)			9b. CITY	r, TOWN	OR LOCATI	ON OF DE		,		NTY OF DE	
R	Howard Cou	nty Ge	eneral Ho	spital		Columbia						Howard		
DIRECTOR	RESIDENCE OF DEC	10b. COUNT	v											
E	MD	Howa			10c. CI	10c. CITY, TOWN OR LOCATION Columbia						10d. INSIDE CITY LIMITS?		
	10e. STREET AND NUMBER	HOWA	<u> </u>			101. ZIP CODE								1 YES 2 NO
FUNERAL	5571 Nettle	ebed C	ourt!				10	210					aiti	HAT COUNTRY?
5	11. MARITAL STATUS		12. WAS DECEDER	T EVER IN U.S		13.	WAS DEC	ENDENT (OF HISPAN	HC ORIGIN? (Specify Yea	or No-	14. RACE	- American Indian, White, atc.
ВУ	1 Never Married 2 Merried 3 Wildowed 4 Divorced FORCES? 1 YES, GIVE WAR OR							2 X NO		n, Puerto Rice	en, atc.)		Specify	Black
COMPLETED	(Specify on)	EDENT'S EDU y highest grade	e completed)		Give kind of	Work done	CCUPATIO	ON ost of worki	ng	16b. KI	ND OF BUS	SINESS/IN		
12	Elementary/Secondary (0	1-12)	None		omemak	ŕ				O	vn Ho	me		
N I	17. FATHER'S NAME (First, M	licidle Leet)	None	110	Onlenas	CT.		40 1107	UCO10 MA	ME (First, Mide				
	Moleus		n						evie			umame) Unkn	own)	
BE	19a. INFORMANT'S NAME (7	ype/Print)			19b. MAILING	ADDRES	S (Street a	000		Route Number,	,			
2	Josette Pierre	-Philip	pe (Daught	er)	5571	Nett	lebe	ed Co	urt,	Colu	mbia,	MD	2104	45
	20a. METHOD OF DISPOSIT 1 Burlet 2 □ Cremetto 4 □ Donation 5 □ Other	n 3 🗆 Rem	novat from Stata	20b. PLA	CE AND DATE	OF DISPOS	nete	me of	July	7 DATE 1995			City or Tow	yn, State Y, MD
	21. SIGNATURE OF FURBYIA		CENSEE	0	00	22.	NAME A	NO ADDRE	SS OF FA	CILITY				
		ecco		Le		55	55 ⁻ 1	win	Knol	l Witz ls Rd.	. Col	umbi	a MD	ome 21045
	23. PART I. Enter the d	lseasea, or	complications the	t coused the	death. Do	not enter	the mo	de of dy	Ing, auci	h aa cerdiad	or respi	ratory ar	reat,	Approximata
	IMMEDIATE CAUSE (Fir		clar only blie car	Jae Dil each	iine.									Interval Between Onset and Death
1 1	disease or condition resulting in death)	→	Stro	ke										24 hours
				(OR AS A CO		,								
Z	Sequentially list condit	ions.	Puln	nonary	edema	with	re	spira	atory	fail	ure	prem	mmi	48 hours
CERTIFICATION	If any, leading to imme- cause, Enter UNDERLY	diate	DUE TO	(OR AS A CO	NSEQUENCE O	F):					,	1		2/01/1-5
윤	CAUSE (Disease or Inju			CVD), (n.								310 years
Ē	that initiated events resulting in death) LAS	т		etes M			Izrno	rtono	ıd on					> 104200
핑		-												1 0
N N	PART II. Other significe			death but n	ot resulting	In the ur	nderlyIn	g cause :	given in	Pert I. 24	a. WAS AN			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDICAL	REnal Insu	ffici	ency			. <u> </u>				_ 1	YES 2	NO		COMPLETION OF CAUSE OF DEATH?
M														1 - YES 2 - NO -
ž	DID TOBACCO U	SE CONT	RIBUTE TO CA	USE OF D	EATH Y	ES 🔲 I	NO X	UNC	ERTAIN	1 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:	26. F	PLACE OF DEA	TH (Check								
YSI	1 TES 2 XNO		1 X Inpatient 2 (ER/Outpatier	H 3 DOA			10 5 🗆 Re	sidence	6 Other (S	pecify)			
	THE -	Pending	25e. DATE OF (Month, I		26b. TIN	IE OF JURY M		URY AT PRK? YES 2	NO	28d. DEŞCR	IBE HOW IN	JURY OC	CURED	
D BY	3 Suicide 6	Investigation Could not be	28e. PLACE C building.	OF INJURY — A etc. (Specify)	t home, term,	street, tack				26f. LOCATIO	ON (Street e.	nd Number	or Rural Ro	oute Number,
ETE		determined										. <u></u> -		
COMPL			ICIAN: To the best of											
00	2 I MEDI			xamination and	d/or investigation	on, in my o	pinion, d	eath occur	red at the	time, date end	d place, and	d due to th	ne cause(a)	end menner se stated.
BE (296. SIGNATURE AND TITLE	OF CERTIFIE	ROC	2					ENSE NUM			29d. DAT	E SIGNED	Month, Day, Years
70		1	5 7	ur				D2	5210	1		▶ 4	wy 6	, 1773
	Jerry E. Se						DR-	ve.	E114	cott	City	MD	21043	3
	31. DATE FILED (Month, Day	1945 ·	32 1984	PER CHARLE	A.		באנט		*****	COLL	отгу,	ĽШ	21043	
	JUL 1 0 1	133	The second											



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAM: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAN	D / DEPAI CERTIF	RTMENT	OF H	EALTH	AND	MENTA	L HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)								OF DEATH			3. TIME OF DEATH
ľ	Betty E	laine Guthrie						TIT	_	AY 1 (YEAR	1310 M
	4. SOCIAL SECURITY NUMBER		s. lest birthday)	IF UNDER	1 YEAR	IF UNDER		7. DATE	ÓF BIRTH			PLACE (State or Foreign
	216 44 5175	1 □ M 2 X F 51	YRS.	MONTHS	DAYS	HOURS	MIN.	Apri	1 22,	1944	Mar	yıand
œ	9a. FACILITY NAME (If not institution, give s	,		12.5		R LOCATIO	ON OF D	EATH		9c. COUN	ITY OF D	EATH
DIRECTOR	Deaton Medical	Center		Bal	timo	re				N/A		
REC	10a. STATE 10b. COUNTY	Y	10c, CI1	Y, TOWN C	R LOCAT	ION						10d. INSIDE CITY
	-	e Arundel	Ba	ltim	ore							LIMITS?
3AL	104. STREET AND NUMBER	mare Dadas			.101	ZIP CODE				_		VHAT COUNTRY?
FUNERAL	5519 Patrick He		T. Carrier			212					.S.A	
	1 Never Married 2 Married FORCES? 1 YES 2 NO If yes, specify Cuban,						n, Mexica	in, Puarto I		or No—	Black	— American Indian, I, Whita, etc.
B	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2X NO						Specif	y :			Speci	white
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION 16e completed)	DECEDENT'S	work done o	CCUPATIO	N st of workin	ю	18b.	KIND OF BU	SINESS/IND	USTRY	
ZE.	Elementary/Secondary (0-12)	College (1-4 or 5+)	Office	se retired.)					State	of M	n we ve 1	- ~ d
MO	17. FATHER'S NAME (First, Middle, Last)		OITICE	CIC	LIX	10 MOTI	JED'C NA		Middle, Maiden		агут	anu
BE C		aymond R. Guth	rie			10. 11011			• Prit			
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS	(Street a	nd Number			per, City or Tow			
F	Donald Guthrie		221 L:	ist A	venu	ie .	P	asade	ena, M	aryla	nd 2	21122
	20a, METHOD OF OISPOSITION 1 A Burlai 2 Cremation 3 Ram	oval from Stata 20b. PLA	CEAND DATE	OF DISPOS	ITION /Na	me of		DAT	20c. LO	CATION — C	City or To	wn, State
	4 Donation 5 Other (Specify) 21. SIGNATURE OF TUNERAL SERVICE LIC	G1e	n Have	n Mei	mori	al P	ark	7/8	G16	en Bu	rnie	, Maryland
	10/1 5	2 '		η G∈	eorge	e J.	Gon	ce F	uneral			
	23. PART I. Enter the diseases, or o	Josmeski	ushi	40	001 1	Ritch	nie	Hwy.	Balt	imore	, Mo	
	enock, or heart tallure	List Dnly Dna cause Dn aech	ilne.	not enter	tne mod	DA DT CYL	ng, auc	n as card	Hec or reap	iratory em	eat,	Approximata Interval Between
	IMMEDIATE CAUSE (Finel diseese or condition	Cancer a	10,	ine	1	ort	1.	0000	1	1211		Onset and Death
	reaulting in death)	BUE TO (OR AS A COR	NSEQUENCE O	F):	C	4	~ /	Mas	tas 1	133		monte
Z	Sequentially liet conditions,	b										
ATI	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CO	NSEOUENCE O	F):								
FIC	CAUSE (Disease or injury that initiated events	c. DUE TO (OR AS A COR	NSEQUENCE O	F):								
CERTIFICATION	reaulting in death) LAST	d										
	PART II. Other significent condition	s contributing to deeth but n	of resulting	in the un	derlylna	COURA	diese de	Dart I	24a, WAS AN	ALITTOREN	Lan	WERE ALEXANDER
CAL			or resulting	iii tiile dii	derlynig	coupe 9	nven m	rait i.	PERFOR	IMED?	240.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
AED								_	1 TYES 2	∠ NO		DF DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONTI	RIBUTE TO CAUSE OF D	EATH Y	S 🗆 N	10 🛮	UNC	ERTAII	N D				1 TES 2 NO
CIAI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	28. F	PLACE OF DEA	TH (Check t	only one)			-				
YSI	1 TYES 2 NO	HOSPITAL: 1 Inputient 2 ER/Outputien	R 3 🗆 DOA	OTHER 4 Mura		5 🗆 Ras	sidenca	6 🗆 Other	(Specify)			
	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF	28c. INJU	RK?		28d. DES	CRIBE HOW I	NJURY OCC	URED	
B	2 Accident Investigation	28e. PLACE OF INJURY — A	t home form	M		ES 2	NO	201.100	ATIONI (Comment			
COMPLETED	4 Homicide 8 Could not be	building, atc. (Specify)	t trome, retin,	ottoot, recti	ory, direct			City o	ATION (Street a or Town, State)	ina Number (or Hurai H	oute Number,
E	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of my knowledge	death occurr	ed at the 1	me data	and place	and due	to the cau	ee/e) and mar	nos es elete	d	
OM		R: On the beals of examination and										and manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER					29c. LICE						(Month, Day, Year)
TO BE	CPriebs	and				203	49	74		D 7	-3	95
-	30. NAME AND ADDRESS OF PERSON WHO				1	1 ^			2 1			
ļ	31. DATE FILED (Month, Day, Year)	Oliver 61, #1		,0	Cu 2	woi	C /	MD	210	45		
	JUL1 01995 July	a welco hardell	16									
	- (/-											

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DIVISION OF VILAL RECORDS, P.O. BOX 68/60	ificate	phys	her
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	death	afte	7,0
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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funibe filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical exam
		_	_

							9	5 20771
	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPA CERTI	RTMENT OF	HEALTH AND F DEATH	MENTAL HYGIEN	-	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATN		3. TIME OF DEATN
	Julia R. Gund	dersdorff				July 7.	1995	7:35 P.M.
1	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE	E (In yrs. last birthday) IF UNDER 1 YEA	R IF UNDER 24 HRS.	7. DATE OF BIRTH	1773	8. BIRTNPLACE (State or Foreign
	579- 50- 4342	1 - M 2 A F 5	7 YRS.	MONTHS DAY	B HOURS MIN.	(Month, Day, Year)		Country)
	9s. FACILITY NAME (If not institution, give					Dec. 13,		Ohio
000					N OR LOCATION OF		9c. COU	NTY OF DEATH
DIRECTOR	6236 Gilston	Park Rd.		Cato	onsville l	Md.	Balt	imore Co.
ည	10a. STATE 10b. COUNT	rv .	1 10: 0	TTY, TOWN OR LO				
<u>E</u>	14.1		100. 0	Catons				10d. INSIDE CITY LIMITS?
	Dal	ltimore		Catons	/1116			1 TYES 2 NO
FUNERAL	10s. STREET AND NUMBER				10f. ZIP CODE		10g. CITI	IZEN OF WHAT COUNTRY?
E	6236 Gilston	Park Rd.			21228		I	U.S.A.
3	11. MARITAL STATUS	12. WAS DECEDENT EVER		13. WAS (ANIC ORIGIN? (Specify Ye		14. RACE — American Indian,
	1 Never Merried 2 Married	FORCES? 1 YES		If yes,	specify Cuben, Mexic	cen, Puerto Rican, etc.)	0 01 110-	Black, White, etc.
B≼	3 Widowed 4 Divorced	IF TES, GIVE WHIT ON	DATES	יטי	ES 2 NO Spec	offy:		Specify: White
0	16. DECEDENT'S EDU	JCATION	164 DECEDENT	'S USUAL OCCUP	TION	16b, KIND OF BU	A11500 (1110	
	(Specify only highest grad	e completed)	(Give kind o	f work done during	most of working	100. KIND OF BU	SINESS/INU	JUSTAT
اڭرا	Elementary/Secondary (0-12)	College (1-4 or 5+)						
COMPLETED		4	HC	memaker			n Hon	ie
18	17. FATNER'S NAME (First, Middle, Last)	-1-				AME (First, Middle, Maider		
BE	Winston W. Mar:	SN			June E.	Baumgartn	er	
TO BE COM	19e. INFORMANT'S NAME (Type/Print)		19b, MAILIN	IG ADDRESS (Stre	et end Number or Rure	I Route Number, City or Tov	vn, State, Zip	Code)
F	Raymond K. Gunder	rsdorff	6236	Gilsto	n Park Ro	oad Catonsv	ille,	Maryland 21228
	20a. METHOD OF DISPOSITION	26	D. PLACE AND DAT	E OF DISPOSITION	(Neme of	DATE 20c. LC	CATION -	City or Town, State
	1 Buriel 2 Cremation 3 Ren 4 Donation 6 Other (Specify)	noval from State ce	emetery, cremetory or	other place)				
	21. SIGNATURE OF FUNERAL SERVICE LI	CENTRE	erro Cre	matory	AND ADDRESS OF F	1995 ICat	onsvi	lle,Maryland
		1					zko E	Tuneral Home
	TESSER.C.	every						sville Maryland
	23. PART I. Enter the diseases, pr	complications that cause	ed the death. Do	not enter the	mode of dving, su	ch as cardiac or resn	Iratory err	rest, Approximate
	snock, or nesrt failure.	List only one cause on	esch line.		,			Interval Between
1 1	IMMEDIATE CAUSE (Finel disease or condition	0	-					Onset and Deat
	resulting in death)	s. Kespirate	bry In	suffici	ency			5 den
		DUE TO (OR AS	A CONSEQUENCE	OF):	1			
z		. Amyotra	phic l	ateral	Scleros	1.5		3 years
은	Sequentially list conditions, If any, leading to immediate	DUE TO (OR AS	CONSEQUENCE	OF):				1-1-2
8	cause. Enter UNDERLYING							
Ē	CAUSE (Disesse or Injury that Initieted events	DUE TO (OR AS	A CONSEQUENCE	OF):				
CERTIFICATION	resulting in death) LAST							
ᄬ		d						
4	PART II. Other aignificent condition	ns contributing to death	but not reaulting	In the underly	ing ceuse given in			24b. WERE AUTOPSY FINDINGS
2						PERFO		AVAILABLE PRIOR TO COMPLETION OF CAUSE
品						12 YES	NO I	DF DEATH?
Σ	DID TOPLOGO HET COLUM				_			1 TYES 2 NO
PHYSICIAN: MEDICAL	DID TOBACCO USE CONT	RIBUTE TO CAUSE (OF DEATH Y	ES NO	☐ UNCERTA	IN 🛛		The state of the s
8	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DE		10)			
S	1 TYES 2 NO	HOSPITAL: 1 Inputient 2 ER/Out	tpatient 3 DOA	OTHER:	ome 5 M Residence	6 Other (Specify)		
<u> </u>	27. MANNER OF DEATN	28e. DATE OF INJURY	28b, TI	_	NJURY AT	28d. DESCRIBE NOW	NJURY OCC	CURED
	1 Natural 5 Pending	(Month, Day, Year)		NJURY	WORK? YES 2 NO			
A	2 Accident Investigation	26e. PLACE OF INJUR	Y _ At home for-					
요	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Spe	ecify)	, street, factory, or	TICE	City or Town, Stete		or Rural Route Number,
ETED	i secondo	20						
7	29e. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of my know	wiedge, death occu	rred at the time, d	ate end piece, end du	e to the cause(s) and me	nner es state	ed.
COMPL								e csuse(e) end manner es stated.
1	29b. SIGNATURE AND THE OF CERTIFIE							
H	Domay 10.	Mrs. 1.0	1	DL	29c. LICENSE NU		29d. DATE	E SIGNED (Month, Day, Year)
2	W. O. W.	much mine	(James	Physicia	n H8295)	7	uly 8, 1995
_	30. NAME AND ADDRESS OF PERSON WA	O COMPLETED CAUSE OF D	EATN (ITEM 27) (Typ	e, Print)				

600 NORTH WOLFE STREET



ANDREA MARKL CORSE, M.D. MEYER 5-119

31. DATE FILED (Month, Day, Your)

JUL 1 0 1995 Julia Daniele Daniele Daniele

BALT., MD 21287

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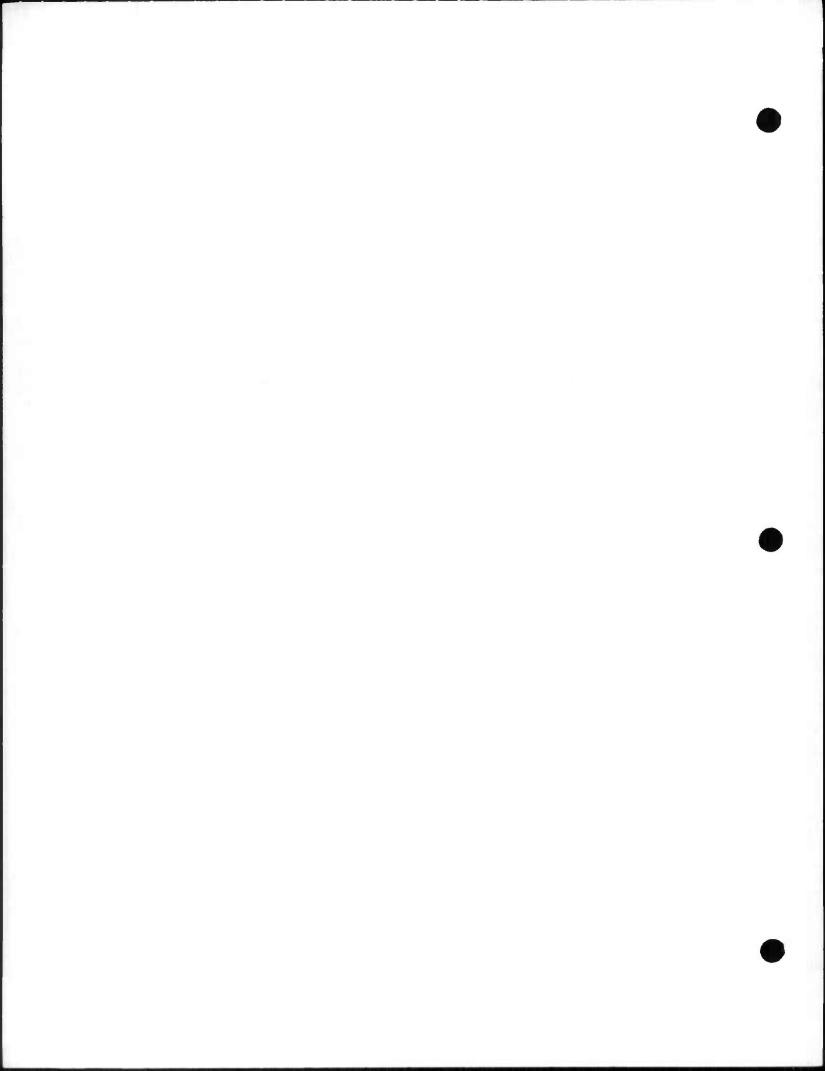
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for use as the burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
10	10	De fil	M

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR CERTIFI	TMENT OF H	EALTH AND	MENTA	L HYGIEN				
Š	1. DECEDENT'S NAME (First, Middle, Last) Edwin L. G	erhardt				2. DATE		7 , 199	EAR	O200 AM	
	4. SOCIAL SECURITY NUMBER 219–14–0077	Worden Francisco Property Francisco Property Company						T a	BIRTHPI Country)	LACE (State or Foreign	
FOR	90. FACILITY NAME (If not institution, give str St. Agnes Hospital RESIDENCE OF DECEDENT	eet end number)		Baltim	OR LOCATION OF D			9c. COUNTY	OF DEA	TN	
DIRECTOR	10e. STATE 10b. COUNTY Maryland Baltir	more	7.1	TOWN OR LOCA	ION				- 1	0d. INSIDE CITY LIMITS? YES 2 \ NO	
FUNERAL	100. STREET AND NUMBER 4926 Leeds Avenue		12.00		21227			10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
ΒY	11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 X NO	If yes, sp	ENDENT OF NISPA ecify Cuban, Mexic 2 NO Speci	an, Puerto	N? (Specify Yea Ricen, etc.)		RACE -	- American Indian, White, etc.	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION 1 20mpleted) College (1-4 or 5+)	6a. DECEDENT'S I (Give kind of w life. Do NOT use ACCOUNTS	ork done during mo retired.)	ON st of working	164	Avai		RY	*	
BE COM	17. FATNER'S NAME (First, Middle, Last) Clinton Gerhardt		necount	IIIC	16. MOTNER'S NA			Surname)			
TO B	190. INFORMANT'S NAME (Type/Print) Margaret Vetter				nd Number or Rurel ive Ellic		ber, City or Town	n, State, Zip Coo			
20c. METHOD OF DISPOSITION 1 X Burlel 2 Cremetton 3 Removel from State 4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of your place) Commettery, cremetory or other place) LOTTAINE Park Cemetery Woodlawn, I								Mar	yland		
	21. SIGNATURE OF PUNERAL SERVICE LICE) iso		1630 E	M & Russ dmondosr	n Ave	nue Ca	tonsvi	lle	l Homes Maryland	
	23. PART I. Enter the disease, or co ahock, or heer feliure. L IMMEDIATE CAUSE (Final disease or condition resulting in death)	ist only one ceuse on eec	h line.							Approximate interval Between Onset and Peath	
MOIT	IMMEDIATE CAUSE (Final disease or condition resulting in death) A CUTE MUDICANDI OI JUGORCHON DIFTO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	ceuse, Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A C	ONSEQUENCE OF	:							
MEDICAL C	PART II. Other algoriticent conditions Di abeja	contributing to death but Melly HV.	not reaulting in	the underlying	cause given in	e given in Part I. 24a. WAS AN / PERFORI			A)	ERE AUTOPSY FINDINGS MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?	
AN: ME	DID TOBACCO USE CONTR				UNCERTAI	N 🗆			1	YES 2 NO	
PHYSICIAN:		HOSPITAL: 1 Inpatient 2 ER/Outpati		OTHER:	5 🗆 Residence	8 🗆 Othe	or (Specify)				
ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending Investigation	28e. DATE OF INJURY (Month, Day, Year)	26b. TIME INJU	RY WO	JRY AT RK? ES 2 NO	28d. DE:	SCRIBE NOW IN	IJURY OCCURI	ED		
	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY — building, atc. (Specify,	At home, ferm, st	reet, fectory, office	,	2st. LOC City	CATION (Street e or Town, Stele)	nd Number or F	lurai Rou	te Number,	
29c. CERTIFFIER (Check only one) 29c. MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner as stated.										nd manner as stated,	
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI	MBER		29d, DATE SIG	GNED (M	Ionth, Day, Year)	
Ē	30. NAME AND ADDRESS OF PERSON WHO GABALL B. DE GAR	COMPLETED CAUSE OF DEATH	AGNES	Print)	911	CATO	J AVE	NUE .	SAL	7, 1995 TIMONE MB	
	JUL 1 0 1995	Wasadan Card	基								



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760 . OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate his hours after death with the State D

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

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2 Accident

3 Suicide

4 Homicide

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TO THE HOSPITA
TO THE FUNERA
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IMPORTANT: I

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	the attending physician and completely filled in by the funeral director, page S should be detached for use as the burial-transit p I Mental Hygiene prior to burial, cremation, or remoral.	
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DIA C	th ar	ашу
dulle	cate has been signed by the attending physic State Dept, of Health and Mental Hygiene pri-	item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once
I. Hills law requires	pt. of	3 sh
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ages 1, 2, 3 should

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH July 7, YEAR Margaret Rebecca Gouker 1995 11:25 am 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, You IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 215-07-1615 85 DAYE HOURS 1 M 2 X F Aug. 6,1909 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Westminster Nursing & Conv. Center Westminster Carroll RESIDENCE OF DECEDENT 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Carroll Manchester 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3177 C Main St. 21102 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 87 Specify: 3 X Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress Sewing Factory 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Herman Peter Therit Annie Viola Wink BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO AODRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 Phil Miller 2209 Deep Run Rd., Manchester, Md. 21102 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State Old Lutheran CemeteryJuly 10,1995 Manchester, Md. 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNEROL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Eckhardt Funeral Chapel Zc 3 10 3296 Charmil Dr., Manchester, Md. 23. PART I. Enter tile dieeeses, or complicatione that caused the death. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, shock, or heart feliure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Finel Onset and Death emphysema disease or condition resulting in death) ears CERTIFICATION Sequentielly list conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE t TYES 2 NO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL **EXAMINER?** OTHER:
4 Nursing Home 5 Residence 8 Other (Specify)

HOSPITAL:

1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF OEATH 28a. DATE OF INJURY 1 Natural 5 Pending

8 Could not be

investigation

28b. TIME OF 28s. PLACE OF INJURY -- At homs, term, street, tectory, office

1 YES 2 NO

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29c. LICENSE NUMBER

Hgts

28c, INJURY AT WORK?

29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

29d. DATE SIGNED (Month, Pay, Year)

28d, DESCRIBE HOW INJURY OCCURED

Vayan

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) washington

31. DATE FILEO (Month, Day, Year) 0 1995

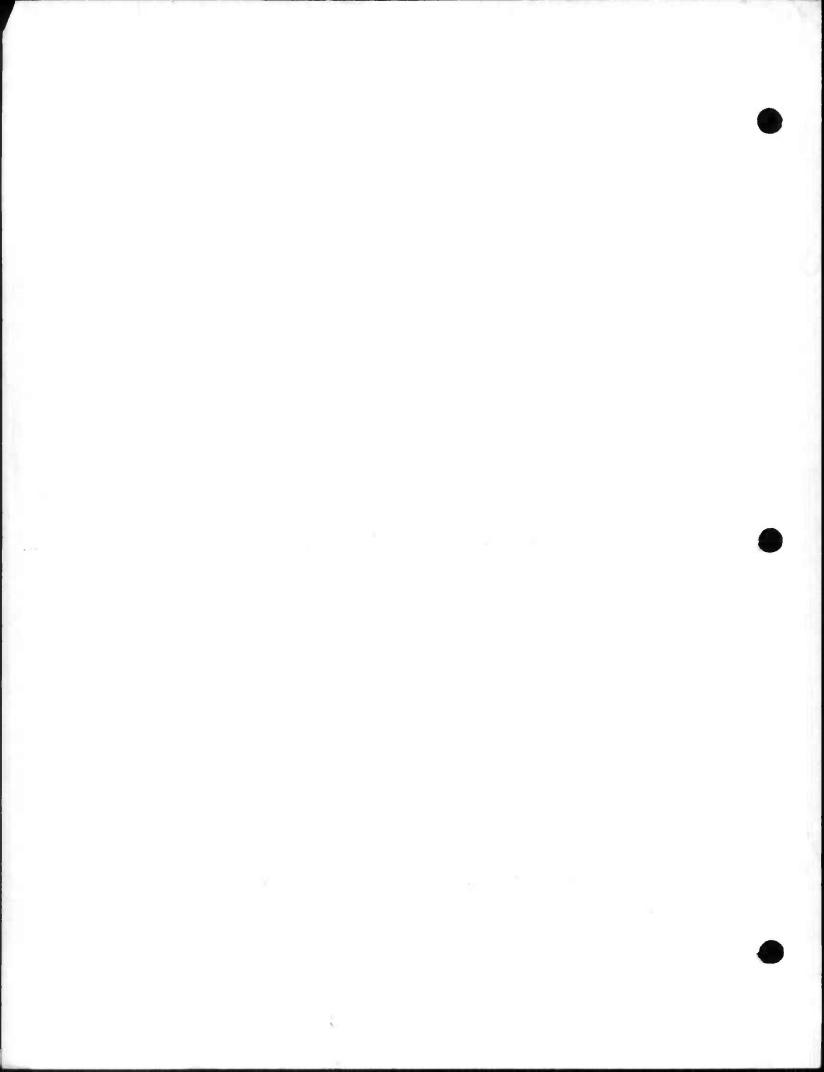
296. SIONATURE AND TITLE OF CERTIFIER

32. REGISTRAR'S SIGNATURE

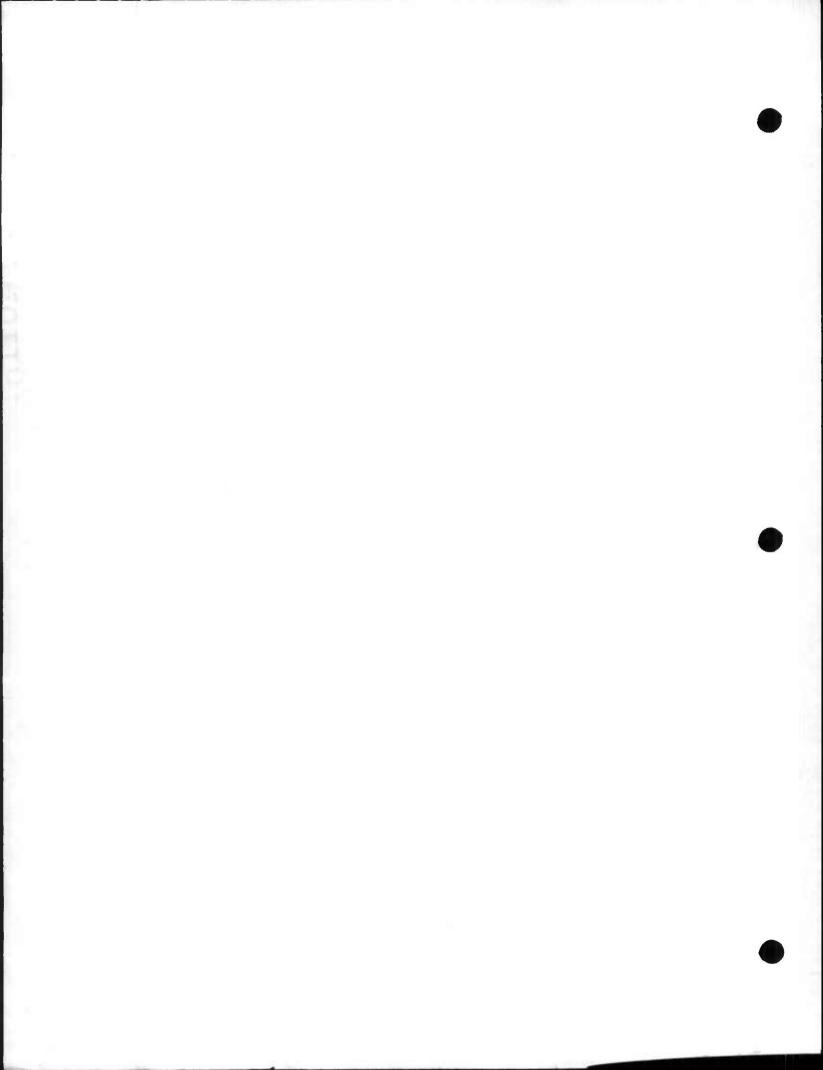
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. . .

		1 - STATE REGISTRAR	STATE OF MA	ARYLAND	/ DEPAR	RTMENT	OF H	EALTH AND	MENT	AL HYGIEN REG. NO.	E		
		1. DECEDENT'S NAME (First, Middle, Lest) ADELE GIBSON						1	2, DAT	4 4	3	YEAR 3.	TIME OF DEATH
2, 3 should		ACTIVITIES AND ACTIVITIES	5. SEX 6		lasi birthday) 5 YRS.	IF UNDER	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	(Moi	E OF BIRTH oth, Day, Year) ruary6			and
	DIRECTOR	99. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH											
permit. Pages 1,		RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY Maryland Balti	more			y, TOWN O							d. INSIDE CITY LIMITS? YES 2 NO
is:	FUNERAL	10e. STREET AND NUMBER 2300 Dulaney Valley					-	ZIP CODE)4				T COUNTRY?
215-0020 attending physician. se as the burial-transit	TO BE COMPLETED BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	2. WAS OECEDENT E FORCES? 1 _ IF YES, GIVE WAR	YES 2 [ARMED NO	1 16	yes, spe	ENDENT OF HISP ecify Cuben, Mexic 2 NO Spec	cen, Puerto	IN? (Specify Yes Ricen, atc.)	or No-	Black, W	American Indian, hite, etc.
To les		15. DECEDENT'S EDUCAT (Specify only highest grade co Elementary/Secondary (0-12)	TION mpleted) College (1-4 or 5+)	16a.	DECEDENT'S (Give kind of the Do NOT us	work done di	CUPATIO	on si of working	16	b. KIND OF BUS	INESS/IND	JSTRY	
retained by 5 should be notified at		17. FATHER'S NAME (First, Middle, Last) Clifton Joseph Hard	dy					18. MOTHER'S N		Middle, Maiden		7S	
		190. INFORMANT'S NAME (Type/Print) Margo Gibson 200. METHOD OF DISPOSITION			1002	Bitte	ersw	eet Rd.	, Ba	Ltimore	, MD	21208	
Page 6		1 Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEN		cemetery,	cremetory or o	ther plece)	•	ID ADDRESS OF F	PACILITY C			ity or Town,	
	4	23. PART I. Enter the disesses, or con	Desc	e		655	W.	Baltim	ore S	ST., Ba	lto.,	MD 2	1201
ted within 24 hours after completely filled in by the ial, cremation, or remove: event, the medical		SHOCK, OF REST ISSUITS. LIS	BREA	ST	ine.	NCE				unac or reepn	atory are	701,	Approximate Interval Between Onset and Desth
te be execu-	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OI	R AS A CONS	SEQUENCE OF	F):							
th certification in Hygier	CERTIF	that initiated events resulting in death) LAST OUE TO (OR AS A CONSEQUENCE OF): d.											
2 2 6 2	ادا	PART II. Other significant conditions of	contributing to de	eth but no	t resulting	In the und	lerlying	cause given l	n Part I.	24a, WAS AN PERFORI	MED?	AWA	RE AUTOPSY FINDINGS ILABLE PRIOR TO MPLETION OF CAUSE DEATH?
has Dept	A	DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL EXAMINER?			ATH YE			UNCERTA	IN)XI			10	YES 2 NO
PHYSICIAN: this certifica with the St wed, or it	PHYSICI		OSPITAL: inpatient 2 El 28a. OATE OF IN. (Month, Day,	JURY	28b. TIM		ng Home 28c. INJU WOI	PK7	- 1	or (Specify) SCRIBE HOW IN	HOSPI JURY OCCI		
TTENDING TOR: After after death	TED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF II building, atc	NJURY At (Specify)	home, ferm, s			ES 2 NO	28f. LOI City	CATION (Street er or Town, Stete)	nd Number o	r Rural Route	Number,
로 작은 도	COMPLET	290. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: (d manner es stated.
TO THE HOSPI TO THE FUNER be filed within	TO BE	296, SIGNATURE AND TITLE OF CERTIFIER ADDITION OF THE PROPERTY OF THE PROPERT	Faul OMPLETED CAUSE	bul DE DEATH (1)	LANZ IEM 27) (Time	O Grant 1		D 250		3	29d, DATE	SIGNED (Mo	nth, Day, Year)
		DR. KENDALL FAULK		0 DUL	ANEY (Y RO	OAD TOW	VSON,	MD 212	204		
		31. DATE FILED WORTH DOWN 1995		books									



		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND /	DEPAR	TMENT	OF I	HEALTH DEA	AND	MENTA	L HYGIEN			-
		1. DECEDENT'S NAME (First, Middle, Last) Mary Agnes	7.10.1							2. DATE	E OF DEATH	AY	YEAR 3.	TIME OF DEATH 9:10 A M
p		218-44-0488	1□ M 2 🖾 F 49	(In yrs. leat	YRS.	IF UNDER	DAYS	HOURS		APR	OF BIRTH th, Day, Year)	946	BALT(O., MD
1, 2, 3 should	TOR	98. FACILITY NAME (If not institution, give street ST. AGNES HOSPITAL RESIDENCE OF DECEDENT				9b. CITY,			IMORI			9c. COUNT BA		ORE CITY
permit. Pages	DIRECTOR	MARYLAND 10b. COUNTY	BALTIMORE			Y, TOWN OF							1	Od. INSIDE CITY LIMITS? YES 2 X NO
sit	FUNERAL	109 MAIDEN CHOICE		o de Lava		1		H. ZIP COD	2122				U.S.	
21215-0020 al or attending physician, for use as the burial-tra	BY	11. MARITAL STATUS 1 Never Married 2 🛣 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 TYPES IF YES, GIVE WAR OR DA	2 📉 N	MED IO	н	f yes, sp	secify Cubi	OF HISPAP pan, Maxica) Specifi	an, Puarto	N? (Specify Yea Rican, atc.)	or No-	American Indian, vhita, atc.	
21 al or to to	PLETED	(Specify only highest grade co	ATION ompleted) College (1-4 or 5+)	(Gir ilfe.	ive kind of v Do NOT us	USUAL OC work done d se retired.)	luring mo	osl of worki	ing	168	SAVING			
MARYLAND 2 retained by the hospital 5 should be detached to notified at once.	BE COMPL	17. FATHER'S NAME (First, Middle, Last) EARL JULIUS KURTH 18. MOTHER'S NAME (First, Middle, Maiden Surname) AGNES ELIZABETH TILTON 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Paral Route Number, City or Town, State, Zip Code)												
5 5 5	10	JOSEPH HUM		1	.09 M	AIDEN	N CF	HOICE			BALTIM	MORE,	MD	21228
0 0 to E		20a_METHOD OF DISPOSITION 1 Disposition 3 Remove 4 Donation 5 Other (Specify)	rel from State cern	PLACE A	ND DATE OF PA	of disposition of the color of	EMET	CERY	-16 28 84	7 / 7		CATION — CIT LTIMOR		Stata
0 = 0	1	Jackie U	l-Shann	or	_	HUI 410	BBAF 07 W	RD FU VILKE	ENS A	L HO	ME, IN JE-BALT	IMORE	, MD	21229
760 ad within 24 hours ompletely filled in al, cremation, or ra		23. PART Enter the diseases, or corshock, or heart feliure. List iMMEDIATE CAUSE (Final disease or condition resulting in death)	PROPERTY OF AS A	ach line.	201	trin	/	1	PCIN			ratory arrea	t,	Approximete interval Between Onset and Death
P.O. BOX 68 th certificate be execu- tending physician and it Hygiene prior to bur or other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST	DUE TO (OR AS A											
CORDS ires that the d signed by the teath and Mer wa any injur	MEDICAL C	PART II. Other aignificent conditions	contributing to deeth be	ut not re	esulting i	n the unc	derlying	g ceuse	given in	Part i.	24a. WAS AN PERFOR 1 YES 2	IMED?	CO OF	ERE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 M NO
AL has bhas be bebt.	AN	DID TOBACCO USE CONTRII				S N (Check o		UNC	CERTAIN	4 				7
다 일 등도	PHYSICI		HOSPITAL: 1 Inpatient 2 ER/Output 28a. OATE OF INJURY	atient 3	□ DOA				lesidence	_			-70	
O H sight by	BY PI	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)		LNI	URY M	1 🗌 Y	YES 2	□ NO	250. VE	SCRIBE NOW II	IJURY OCCU	NEO	
IVISIC R ATTENDI RECTOR: A urs after di	ETED	3 Suicide 6 Could not be determined	26a. PLACE OF INJURY building, etc. (Speci	elly)						City	ATION (Street a or Town, State)			» Number,
# 경절 #	COMPL	One) 2 MEDICAL EXAMINER:	M: To the best of my knowle On the bests of exemination	edge, des	nvestigatio	n, in my op	ne, deta pinion, d	and place	i, and dua	fo fhe cau	and place, and	ner as stated. d dua fo fhe c	:ause(a) an	d manner as stated.
TO THE HOSPI TO THE FUNEF be filed within	TO BE	SIGNATURE AND THE OF CENTIFIER	By th.	ı.h	D			29c. LICI	ENSE NUN	19	0	29d. DATE S	GNED (MG	onth, Day, Year)
/		DIANA HI OR	OMPLETED CAUSE OF DEA	90C	1	Print) ATOL	2	Ave	57	Br	TATIMO	RE,	M	PEG16



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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached a find within 70 hours after death with the State hand of the Health and Mental Hollens note to build in removal or removal.	IMPORTANT: If Item 28 Is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
	PHY	this	rke
	NG.	After	E
	END	B. A	20
	ATT	ECT	2
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JULI 0 1995

HEGISTRAR'S SIGNATURE

											9	0	20182
	FOR 1 - STATE REGISTRAR	STATE OF N	MARYLAND /				HEALTH DEAT		MENTAL	HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE C	F DEATH	_		3. TIME OF DEATH
		Virginia	Katheri	ine H	ligh				July		AY 7 1	995	5:30 A. M
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. les	at birthday)	IF UNDE	R 1 YEAR	IF UNDER	24 HRS.	7. DATE O	F BIRTH		8. BIRTHI	PLACE (State or Foreign
	217 18 1166	1 🗌 M 2 🔀 F	74	YRS.	MONTHS	DAYS	HOURS	MIN.		30,	1921	Vir	ginia
	9e. FACILITY NAME (If not institution, give s	treet and number)			9b, CIT	Y, TOWN	OR LOCATE	ON OF D		007	-	NTY OF DE	
DIRECTOR	15 Nann Avenue	<u> </u>	Baltimore						Anne Arundel				undel
) E	10a. STATE 10b. COUNT	•		10c. CIT	Y, TOWN	OR LOCA	TtON						10d. INSIDE CITY
5	Maryland Ann	ne Arunde	1	Ba	altin	nore							LIMITS?
AL A	10e. STREET AND NUMBER					10	H. ZIP CODE	E			10g. CIT	IZEN OF W	HAT COUNTRY?
FUNERAL	15 Nann Avenue						212	225			Ţ	J.S.A	
5	11. MARITAL STATUS	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. AR	MED	13.	WAS DE	CENDENT C	OF HISPA	NIC ORIGIN?	(Spectfy Yes	or No-	14. RACE	- American Indian,
B≺	1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE W	MR OR DATES	NO		If you, as	s 2 NO	Specif	en, Puerto Ri fy:	can, etc.)		Specify	, white, etc. y: White
COMPLETED	15. DECEDENT'S EDU	CATION	18e. DE	CEDENT'S	USUAL O	CCUPATI	ON		16b, 1	CIND OF BU	SINESS/IN	DUSTRY	
E	(Specify only highest grade	College (1-4 or 5 +	(G life.	ive kind of Do NOT u	work done se retired.)	during m	ost of working	ng					
14	12th			ome N	laker	1				Own He	ome		
ő	17. FATHER'S NAME (First, Middle, Last)						18. MOTI	HER'S NA	ME (First, Mi	ddle, Meiden	Sumeme)		
BE	E	Bernard M	cCormic)	2					(unkn	own)			
	19e. INFORMANT'S NAME (Type/Print)		191	b. MAILING	ADDRES	S (Street	end Number	or Rural	Route Numbe	r, City or Tow	n, State, Zi	p Code)	
2	Charles R. High	l					Cou						d 21061
	20s. METHOD OF DISPOSITION		20b. PLACE	AND DATE	OF DISPOS	SITION /N	ame of		DATE			City or Toy	
	1 Buriet 2 X Cremetion 3 Rem 4 Donation 5 Other (Specify)	oval from State	Metro	Cre	mato	ry,	Inc.		7/8				Maryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		,	22	NAME A	ND ADDRES	SS OF SA	CHITY				
	1/2 M	2	*	16:					ce Fu				
		mame	MIKE	rel	40	001	Ritch	nie	Hwy.	Balt	imor	e, Md	. 21225
	23. PART I. Enter the diseases, Ore shock, or heart failure	List only one cau	t caused tha da se on aach line	ath. Do i	not enter	tha mo	oda of dyl	ng, auc	ch aa cardi	c or reapi	ratory ar	rest,	Approximata interval Between
	iMMEDIATE CAUSE (Final disease or condition	Anemi	a										Onset and Death
	resulting in death)	a											2 months
		OUE TO	(OR AS A CONSEC	DUENCE O	F):								
NO	Sequentially list conditions,	Dysph	agia (OR AS A CONSEC		_								1 year
AT	if any, leading to immediate cause. Enter UNDERLYING		ageal S			2							3 years
FIC	CAUSE (Disease or injury	C	OR AS A CONSEC										3 70023
ERTIFICATION	that initiated events resulting in death) LAST		ic Obst			Pi i 1m	onary	v Di	SEASE				10 years
E		d	110 0200	L ac c.	100 .	· CL	DIICE J	,	bease				10 70025
	PART ii. Other aignificant condition	s contributing to	death but not r	esuiting	in the ur	nderlyin	g cause g	jiven in	Part i.	4a. WAS AN			WERE AUTOPSY FINDINGS
S										PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
Ä										1 TYES 2	X	- 1	OF DEATH?
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTI	RIBUTE TO CA	USE OF DEA	TH YE	S	NO F	UNC	ERTAII	$\overline{\Box}$				
3	25. WAS CASE REFERRED TO MEDICAL			E OF DEA									
Sic	EXAMINER?	HOSPITAL:	ER/Outpatient 3	□ noa	OTHE		- 5 M n-	aldanaa	6 Other	H - I			
¥	27. MANNER OF DEATH	28e. DATE OF	INJURY	28b. TIM	-	_	JURY AT	siderice		RIBE HOW I	NJURY OC	CUBED	
0	1 Natural 5 Pending	(Month, De	sy, Year)	INJ	URY	WC	ORK? YES 2	ONE				COMED	
ВУ	2 Accident Investigation 3 Suicide & Could get be	28e. PLACE OF	F INJURY — At ho	me, ferm, s	street, fact				28f LOCAT	ION (Street e	and Numbe	or Parmi De	urte Mumber
TED	4 Homicide 6 Could not be determined	building,	atc. (Specify)			,,				Town, State)	nio repriori	OF HOPET PIC	normoni,
2	29e. CERTIFIER (Check only 1 🔀 CERTIFYINO PHYSI	CIAN: To the bast of	my knowledge, de	ath occurn	ed at the t	Ime, date	and place.	and due	to the cava	e(a) and mar	mer ee sta	led.	
COMPLET	one) 2 MEDICAL EXAMINE												end manner se stated.
n n	296 SHEMATURE AND TITLE OR CERTIFIES						29c. LICE						
TO BE	garming	B-M.D.(A	ttendin	-		ian)	D	1416			▶ 0	7/07/	(Month, Day, Year) 95
F	Hartif Singh	COMPLETED CAUS	O-7 Di-	1 27) (Type,	Print)	hr.zaz	Da	1+4	oro	MA 2	1225		***
- 4	Harjit Singh, I	1.D. 541	O-W KIN	CLITE	птді	ıway	Dd.	T C 11()	DIE,	race. Z	1223		

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN; MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM	ENT OF H	EALTH AND A	MENTAL HYGIE			
1. DECEDENT'S NAME (First, Middle, Last)	William Lo				2. DATE OF DEATH MONTH	DAY YE	3. TIME OF DEATH	
4. SOCIAL SECURITY NUMBER			UNDER 1 YEAR		July 3,	1995	11:45P M	
	1 □XM 2 □ F 76	400	THE DAYS	IF UNDER 24 HRS. HOURS MIN.	(Month, Day, Year)		BIRTHPLACE (State or Foreign Country)	
Sa. FACILITY NAME (If not institution, give stre			CITY, TOWN O	R LOCATION OF DE	Nov. 2,1	918 COUNTY	Beorgia DE DEATH	
7863 St. Bridget	Lane		Dundo				timore	
10a. STATE 10b. COUNTY		10c. CITY, TO	OWN OR LOCAT	ION			10d. INSIDE CITY	
Maryland	Baltimore			Dundal	2k		1 TYES 2 NO	
10e. STREET AND NUMBER	1		101.	ZIP CODE	1000		OF WHAT COUNTRY?	
7863 St. Bridget	Lane. 12. WAS DECEDENT EVER IN U	C ADMED	12 440 000	-	1222		ted States	
1 Never Married 2 Merried	FORCES? 1 YES	2 NO	If yes, spe	city Cuban, Maxican	IC ORIGIN? (Specify Y	es or No 14.	RACE — American Indian, Black, White, atc.	
3 Widowed 4 Divorced	II TES, GIVE WAR ON DATE		1 1 453	2 X NO Specify:	:		specify. White	
15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	ompleted)	6a. DECEDENT'S USU (Give kind of work life. Do NOT use ret	IAL OCCUPATIO done during mos	N st of working	16b. KIND OF B	USINESS/INDUST	RY	
6 Years	College (1-4 or 5+)	Electr			E	lectric		
17. FATHER'S NAME (First, Middle, Last)					AE (First, Middle, Maide	n Sumame)		
Media M. Howell				Elvie R				
19a. INFORMANT'S NAME (Type/Print)					oute Number, City or To		-/	
Jeanette Howell	I an a	1863 SA			DATE 20c. L		ryland 21222	
1 X Burial 2 Cremation 3 Remov	ral from State compte	ork crematory of other p	olace). Mom (advis 7/7	/1995 M	iddle D	in to the MD	
21. BIGNATURE OF HUNERAL SERVICE LICE	HSEE O	acy mace	22. NAME AN	D ADDRESS OF FAC	HUTY	tuuce 10	idalk, Inc.	
Tregon 6	2 Keen		7922	Wise Aug	. Dundal	ck. MD	21222	
MANEOLATE CALICE (EL-1	Melas fake Due to (or as a co	h line.				piratory arrest,	Approximate Interval Between Onset and Death	
	DUE TO (OR AS A CO	ONSEQUENCE OF):		0 ,0	0.			
Sequentially list conditions, b.	DUE TO (OR AS A CO	ONSEQUENCE OF:	6	ne co	Con			
If any, leading to immediate cause. Enter UNDERLYING		and the transfer of the transf					į	
CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CO	ONSEQUENCE OF):						
reaulting in death) LAST d.								
PART ii. Other significent conditions	contributing to deeth but	not resulting in th	e underlying	cause given in F		N AUTOPSY	24b. WERE AUTOPSY FINDINGS	
				1277	PERFO	PRMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
							1 YES 2 NO	
DID TOBACCO USE CONTRI				UNCERTAIN				
	HOSPITAL:	PLACE OF DEATH (C	HER:					
1 YES 2 NO	1 Inpatient 2 ER/Outpatie 28e. DATE OF INJURY	ant 3 DOA 4 D		5 PRaeldence				
1 Natural 5 Pending	(Month, Day, Year)	INJURY	WOF	RK?	28d. DEŞCRISE HOW	INJURY OCCURE	:0	
2 Accident Investigation 3 Suicide 6 Could not be	28a. PLACE OF INJURY -	At home, farm, atreet			28f. LOCATION (Street	and Number or R	ural Route Number,	
4 Homicide determined	building, etc. (Specify)				City or Town, State	9)		
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.								
296. SIGNATURE AND TITLE OF CERTIFIER 290. LICENSE NUMBER 290. LICENSE NUMBER 290. DATE SIGNED (Month, Day, Year) 7 5 95								
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Pypo, PHIN) LARRY WATERBURY WID JOHNS HOPKINS BAYULEW HED. CENTER BUT HO								
31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGNATE	JRE						

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DIVISION

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 15 hours after death. Page 6 may be retained by the hospital or attending physician.	
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Planes 1.2 showld	
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	

95 20784 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH Catherine 3. TIME OF DEATH Janczak Josephine 10:45 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreig (Month, Day, Year) 6/15/14 HOURS DAYS 2:3-10-2675 1 M 2 X F 81 YRS. Maryland 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Harford Fallston Fallston General Hospital RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Harford Edgewood 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21040 1205 Hanson Rd. USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Maxican, Puerto Rican, etc.)
 T YES 2 X NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY 3 ♥ Widowed 4 □ Divorced Specify White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic 10 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname Victoria Unknown Stanislaus Golembieski BE 19th. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
827 Vandyke Lane Belair, Maryland 21014 19a. INFORMANT'S NAME (Type/Print) 2 Francis M. Janczak Jr. 20a. METNOD OF DISPOSITION

1 St Burlai 2 Cremation 3 Removal from Stata
4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 28c. LOCATION -- City or Town, Stata Sacred Heart of Jesus Cem. 7/12 Baltimore, Maryland 21. SIGNATURE OF CONTRAL SERVICE MICENSES 22. NAME AND ADDRESS OF FACILITY David J. WeberFuneral Homes or complications that caused the deeth. Do not enter the mode of dying, auch ea cardiec or respiratory arrest, nomes 401 S. Chester St. Baltimore, Maryland 21231 23. PART I. Enter the disease Enter the diseases or complications that caused the de-ahock, or heart failure. List only one ceuse on each line. Approximate Interval Betwe IMMEDIATE CAUSE (Finel Onset and Death disease or condition PULMONARY EMBOL1 3 DAYS resulting in death) DUE TO (OR AS A CONSEQUENCE OF): PNEUMONIA 5DAYS CERTIFICATION Sequentially ilst conditiona, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PHYSICIAN: MEDICAL

PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. BREAST CARCINOMA ALZHEIMER'S DISENSE

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO OF DEATH? 1 | YES 2 | NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) 26. PLACE OF DEATH (Check only one)

HOSPITAL:
PUnpetient 2 ER/Outpetient 3 DOA OTHER: 4 - Nursing Home 5 - Residence 6 - Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED

1 YES 2 NO 26a. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify)

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER

(Chart only

1 **CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the Ilme, date and place, and due to the cause(a) and manner as stated.

	MEDICAL EXAMINER: On the beals of examination and/or	Investigation, in my opinion	, death occured at the time,	data and placa, and dua	to the cause(s) and manner ea stated
_					

29b. SIGNATURE AND TITLE OF CERTIFIER Anda Nowa Consi

5 Pending

8 Could not be

Investigation

determined

25. WAS CASE REFERRED TO MEDICAL

EXAMINER?

27. MANNER OF DEATN

1 Netural
2 Accident

3 Suicide

4 Homicide

BY

6

COMPLET

BE

2

29c. LICENSE NUMBER DO 8096

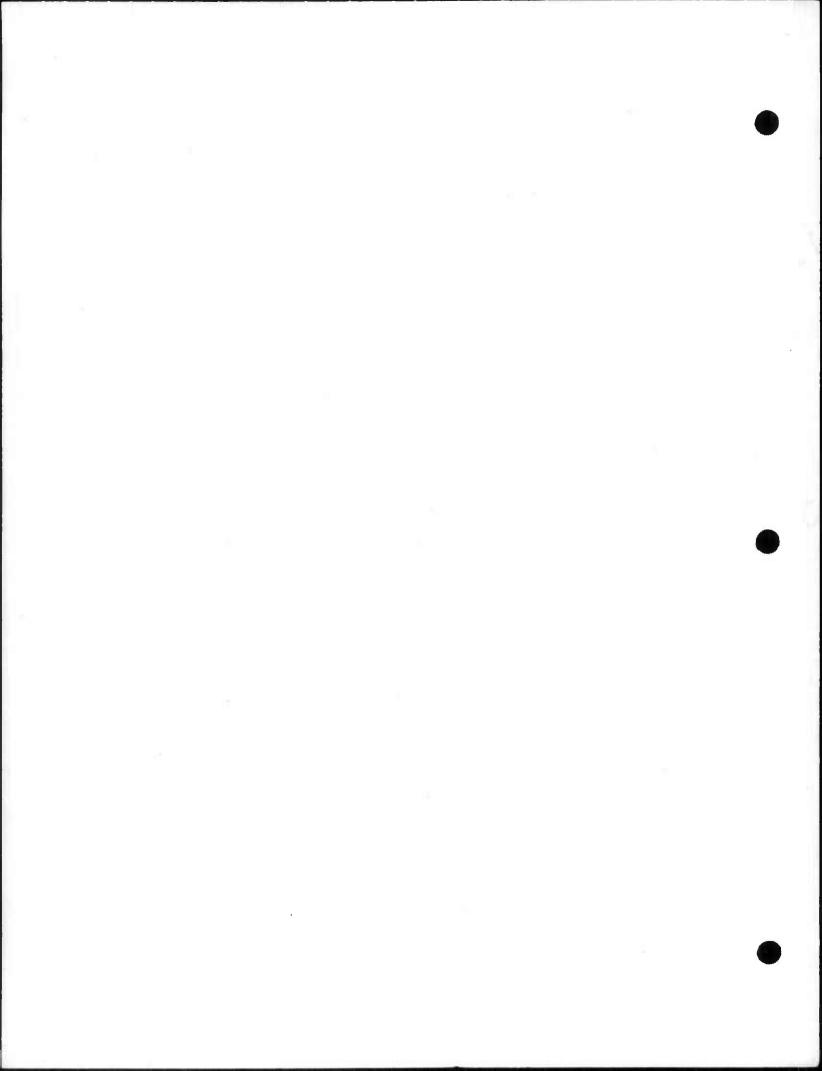
29d. DATE SIGNED (Month, Day, Year) ► JULY 8, 1995

30. NAME AND ADDRESS OF PERSON WND COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) ANDREW NOWAKOWSKI

MD 31. DATE FILED (Month, Day, 16er)

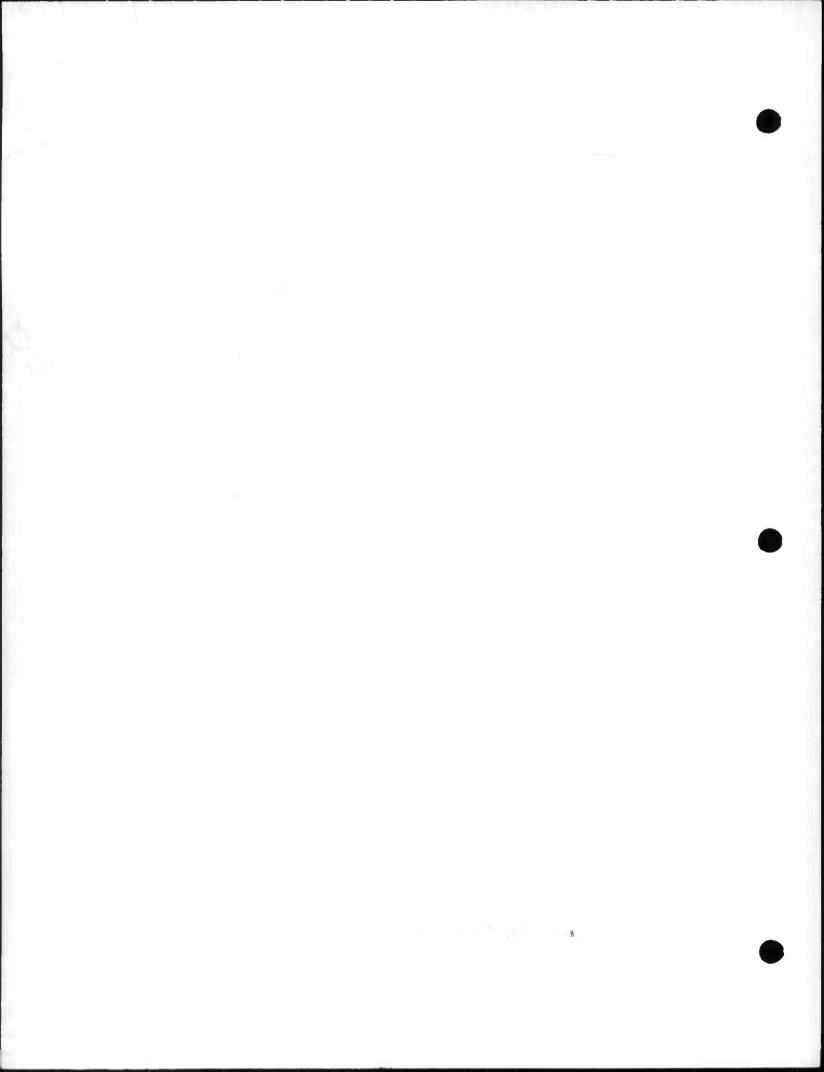
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125 N. MAIN ST, RELATRIMORION



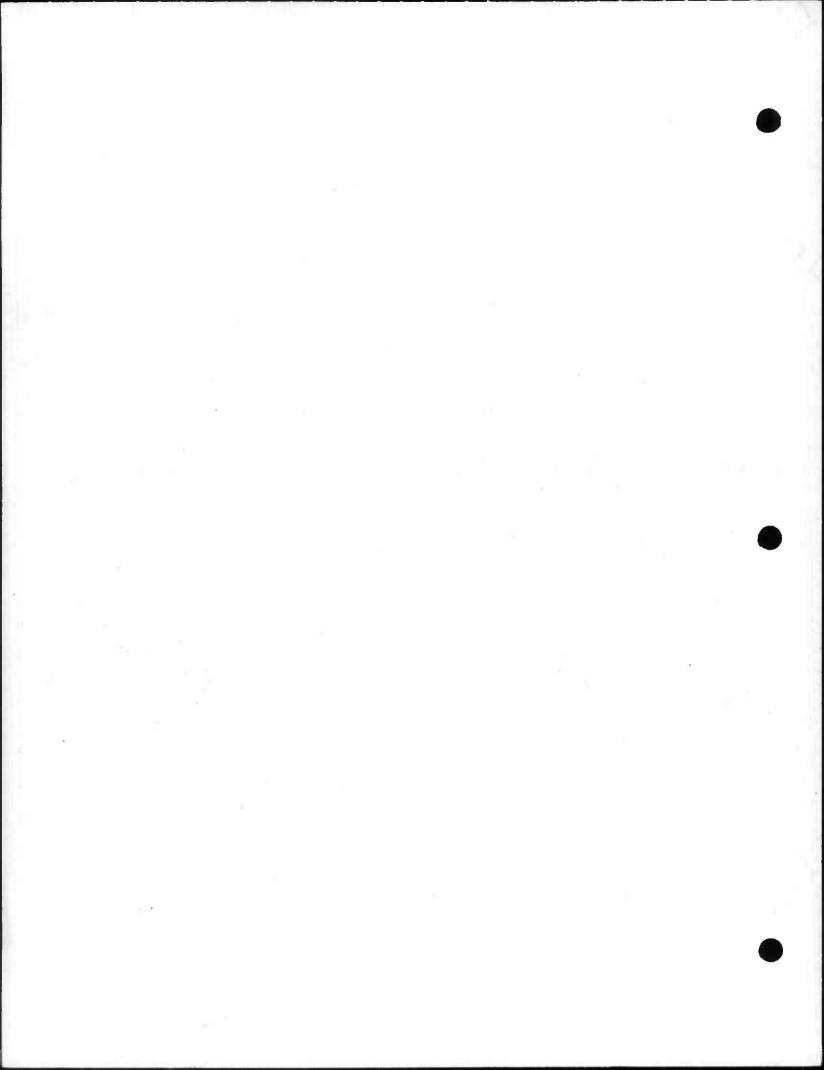
JUL 1 0 1995

	FilmG.	725, item #4	. 7/10/99	- CTM-7	oor f h		95	20785		
	1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPAR	TMENT OF	HEALTH AND N					
	1. DECEDENT'S NAME (First, Middle, Last)	1 10	<u> </u>	IONIE O	DEATH	REG. NO 2. DATE OF DEATH		3. TIME OF DEATH		
	Hazel (C. Keats				MONTH 2	9, 9	3. TIME OF DEATH 3.05 PM		
	223 24 2 308	1 - M 2 - F	(In yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN	Jan. 10,19	8.	BIRTHPLACE (State or Foreign Country) Maryland		
œ	9a. FACILITY NAME (If not institution, give street and number)				OR LOCATION OF OE	ATH	9c. COUNTY	Y OF DEATH		
5	North Arundel	Hospital		Glen I	Burnie		Anne Arundel			
DIRECTOR	10e. STATE 10b. COUNT Maryland Ann	ne Arundel		y, town or Local everna H				10d. INSIDE CITY LIMITS? 1 YES 2 NO		
ERAL	100. STREET AND NUMBER 24 Truckhouse F	₹oad			01. ZIP CODE 21146			N OF WHAT COUNTRY?		
BY FUNERAL	11. MARITAL STATUS 1. Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I	2 NO	If yes,	ECENDENT OF HISPAN apecify Cuban, Mexicar as 2 1 NO Specify	IC ORIGIN? (Specify Yes n, Puerto Rican, etc.) :	or No.— 14	Black, White, atc. Specify: White		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEOENT'S (Give kind of v life. Do NOT us	vork done during i	TION nost of working	16b. KINO OF BUS	SINESS/INDUS	TRY		
MP	unknown		Never	worked		N/A				
BE CO		Tesse W. Ke	eats		Geo	rge Anna	Craf			
5	190. INFORMANT'S NAME (Type/Print) Debra Shurman		19b. MAILING 8131 S	ADDRESS (Street	and Number or Rural R Road Pa	oute Number, City or Tow asadena, M	n, State, Zip Co arylan	nd 21122		
	20e. METHOD OF DISPOSITION 120 Burlel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) Ramoth Cemetery 7/7 Stafford, Virginia									
	21. SIGNATURE OF FUNERAL SERVICE LIC		/	22. NAME	AND ADDRESS OF FAC	e Funeral	Home	D A		
	I flome &	namuou	sho	4001	Ritchie F	wv. Balt	imore.	Md. 21225		
	23. PART I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, ahock, or head-fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition Approximate interval Batween Onset and Death disease or condition									
_	DUE TO (OF AS A CONSEQUENCE OF): 2 days									
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
CER		d								
PHYSICIAN: MEDICAL	DESTRUCTION OF SEIZULE SMILE PRIOR TO COMPLETION OF CAUSE OF DEATH?							COMPLETION OF CAUSE		
M				EUKEM	-	_		1 YES 2 NO		
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO VINCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
SIC	EXAMINER? 1 YES 2 NO	HOSPITAL:		OTHER:						
	27. MANNER OF DEATH 1 Netural 5 Pending	MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? WORK?					26d. DE\$CRIBE HOW INJURY OCCURED			
TED BY	2 Accident Investigation 3 Suicide 6 Could not be datarmined	Y — At home, farm, s	M 1 YES 2 NO Nome, farm, street, factory, office 28f. LOCATION (Street, City or Town, Street)				ret and Number or Rural Route Number, ate)			
COMPLETED	29a. CERTIFIER 1 D CERTIFYING PHYSI	CIAN: To the heat of my leas-	Land to the second second	due to the cause(s) and manner as stated.						
MP				ause(s) and manner as stated.						
BE	Sab BIOMATURI AND TITLE OF CERTIFIER		Mysician)	29c. LICENSE NUMI		29d. DATE SI	IGNEO (Morith, Day, Year)		
5	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	ENTH (ITEM 27) (Type,	undel	Hospitz	1.	Jan	- (- ((117)		
	31. DATE FILED (Month, Day, Hear)	A REGISTRAR'S SIGN								



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within 74 hours after death, Page 6 may be retained by the hospital or attending TO THE FUNERAL DIRECTOR: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the be filed within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLAN	ND / DEPARTM			MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last) Winfield Scott 4. SOCIAL SECURITY NUMBER	t Kauffr		r.		July 07	199	5 /	OSS A M	
	220-22-3386	1 M 2 D F 68	YRS. MON		IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	1927	MAR	CE (State or Foreign YLANO	
HOL	ST. AGNES HOSPI	TY NAME (If not inalitution, give street and number) SNES HOSPITAL BAITIMORE 9c. COUNTY OF DEATH N/A							47.5	
DIRECTOR	10a. STATE 16b. COUNTY	altimore	10c. CITY, 10	De. CITY, TOWN OR LOCATION			10d.			
FUNERAL	100. STREET AND NUMBER 124 Garden Ridge F	AND NUMBER			Catonsville 101. ZIP CODE 21228			10g. CITIZEN OF WHAT CO		
BT FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS OECEDENT EVER IN U. FORCES? 15 YES IF YES, GIVE WAR OR DATE KOLOA	2 NO	If yes, sp	ENDENT OF HISPA ecify Cuban, Mexico 2 NO Specifi	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)	s or No- 1		American Indian.	
COMPLEIED	15. OECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)			done durina mo	N st of working	16b. KIND OF BU	siness/indus		vion	
	17. FATHER'S NAME (First, Middle, Lest) Winfield S. Kauffn	nan	Breed	TCTAIT	18. MOTHER'S NA Julia	ME (First, Middle, Maiden a Johnson		ar or	HOIT	
10 BE	190. INFORMANT'S NAME (Type/Print) Mary Jane Kauffmar	ı (Spouse)	196. MAILING ADD 124 Gard	en Ric	nd Number or Rural Ige Road	Route Number, City or Tow Catonsvil	n, State, Zip C Le, Mar	yland	21228	
	20s. METHOD OF DISPOSITION (C) Burlel 2 Cremation 3 Remov 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	ral from Stata comete	2	metery 22. NAME AN Leroy	July 10 D ADDRESS OF FA M & Russ	1995 Mar	zke Fu	ville neral	,Maryland Homes	
MILICALION	23. PART i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Fine) disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
N. MEDICAL CE	Dung Cancer PERFORMED? 1 yes 2 Date OF DE							E AUTOPSY FINDINGS LARLE PRIOR TO IPLETION OF CAUSE DEATHY YES 2 NO		
SICIAIN		HOSPITAL:	PLACE OF DEATH (O	HER:	5.(1) Residence	6 Dither (Specify)				
	27. MANNER OF DEATH Natural 5 Pending	28s. DATE OF INJURY (Month, Day: Year)	28b. TIME OF	28c. INJI	JRY AT	284. DESCRIBE HOW INJURY OCCURED				
	3 Suicide 6 Could not be determined	3 Suicide 6 Could not be 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28s. PLACE OF INJURY — At home, farm, street, factory, office City or Town Steel							Number,	
	29a. CERTIFIER (Check only one) 29a. CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 29a. CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.									
	296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month) 7/7/6							5		
	30. NAME AND AUTIESS OF PERSON WHO	wo B S	ANDU		2 #	206 466	O W	KKE;	15 AVE	
	JUL 1 0 1995 Jul	32 REGISTRAR'S CHATU	il.					2	21229	



DIVISION OF VITAL RECORDS, P.O. BOX 68760

5.5. DANG JUL 1 0 1995

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: if Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

							95	20/8/		
	1 - FOR STATE REGISTRAR	STATE OF MAR	RYLAND / DEPART	MENT OF H		IENTAL HYGIEN				
	1. DECEDENT'S HAME (First, Middle, Last) JUSTINE		Kelly			2. DATE OF DEATH		YEAR 8:02 A.M		
DIRECTOR	4. SOCIAL SECURITY HUMBER 014-22-2179	5. SEX 6. / 1 M 2 F	GE (In yrs. last birthday) Q 94 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) JULY 19	8	BIRTHPLACE (State or Foreign Country) (ASSAChusette		
	9a. FACILITY NAME (If not institution, give st. SE HON HILL RESIDENCE OF DECEDENT				14/MO	ATH	9c. COUNTY OF DEATH			
	10e. STATE 10b. COUNTY	N.A.	10c. CITY	TOWN OR LOCAT	140Le			10d, INSIDE CITY LIMITS?		
FUNERAL	100. STREET AND NUMBER W. F	FRANKL	in Str		ZIP CODE	7/		H OF WHAT COUHTRY?		
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EV FORCES? 1 1 1 IF YES, GIVE WAR O	YES 2 NO	if yes, spe	EHDEHT OF HISPANI polity Cuben, Maxican 2 N HO Specify:		e or Ho—	4. RACE — American Indian, Black, White, atc. Specify: White		
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATIOH completed) College (1-4 or 5+)	life. Do NOT use	ork done during mos	st of working	18b. KIND OF BU		Home		
Š S	17, FATHER'S HAME (First, Middle, Last)	,	,	.,0,,,,		E (First, Middle, Maider				
BE	HENRY	WILL	-IMMS			SANNA	L	WILLIAMS		
2	19a. INFORMANT'S HAME (Type/Print) HENRY KEL	4	19b. MAILING /			oute Number, City or Tov 54 Reet	7	000) 160 Md 21224		
	20a. METHOD OF DISPOSITION 1 K Burlal 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITIOH (Name of camelery, crematory or other place) CREATED TOWN, Stata 20c. LOCATION - City or Town, Stata									
	Joseph N. Zannin o Jr. Funeral H							Funeral Home		
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory street, ehock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Pt four lead on bed OUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST OUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
PHYSICIAN: MEDICAL C	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. ARTHRITIS CONSTIPATION 246. WAS AN AUTOPSY PHOPHOS MAILBRE PRIOR TO COMPLETION OF CAUSE OF DEATH?									
AN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WINCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
SIS	EXAMIHER?	HOSPITAL:		OTHER:	5 🗆 Rasidence 6	☐ Other (Specify)				
BY PH	27. MAHHER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	ER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF WORK? WORK? M 1 VES 2 NO						RED		
	2 Accident 3 Suicide 6 Could not be determined 26a. PLACE OF IHJURY — At home, farm, street, factory, office building, etc. (Specify) 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(a) and manner as stated.									
M N	29b. SIGNATURE AND TITLE OF CERTIFIER	l · D			29c. LICENSE HUME	DER		SIGNED (Month, Day, Year)		
2	30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) 5. 5. DANG M.D. 101 St. Helena Aug Balto MARYLAND 21222 31. DATE FILED (Month, Day 1965) July 32 Marshalle Randoll									
	S. S. DANG	M.D. 10	54. He	CLENA	AUR.	Balto 1	LARY	LAND 21222		
	111 1 0 1995	LUA" OUT DE LUCIONE	THE PERSON NAMED IN							

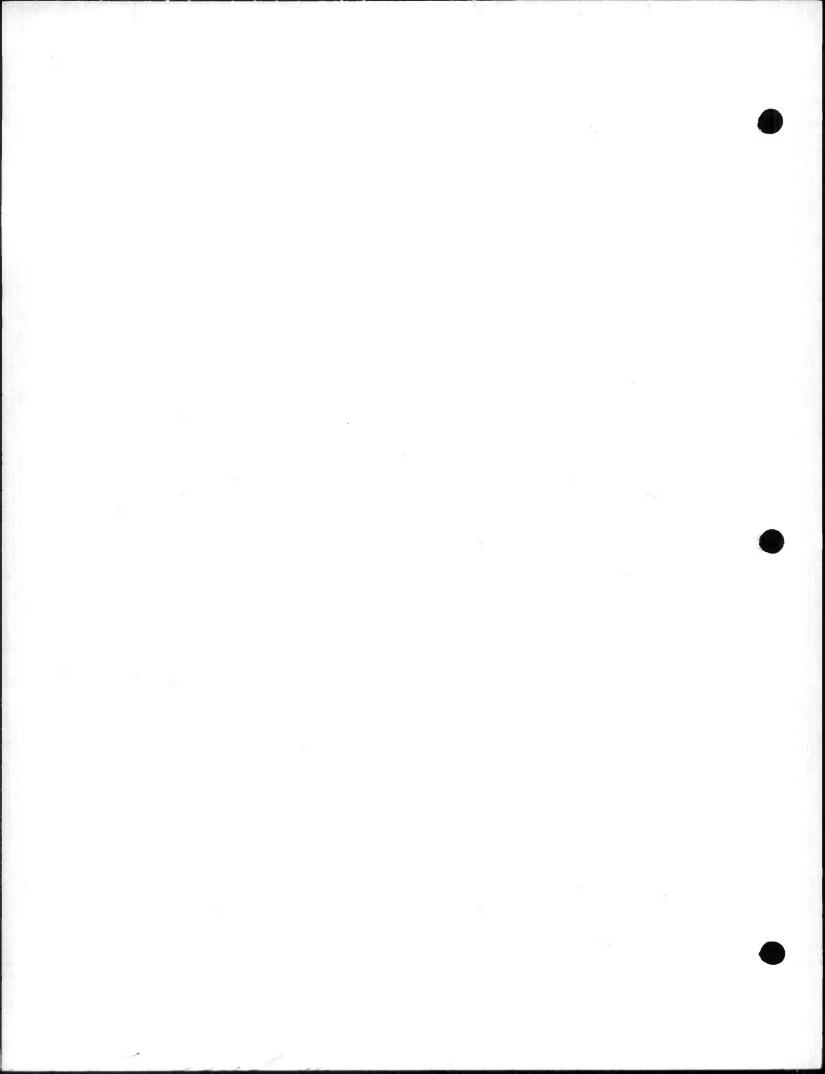
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TO THE HIGSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 6 may be refained by the hospital or attending physician.	TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermin Panes 1.2	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT IS them 90 to married on Name 92 absence many injuries on attachment and an analysis

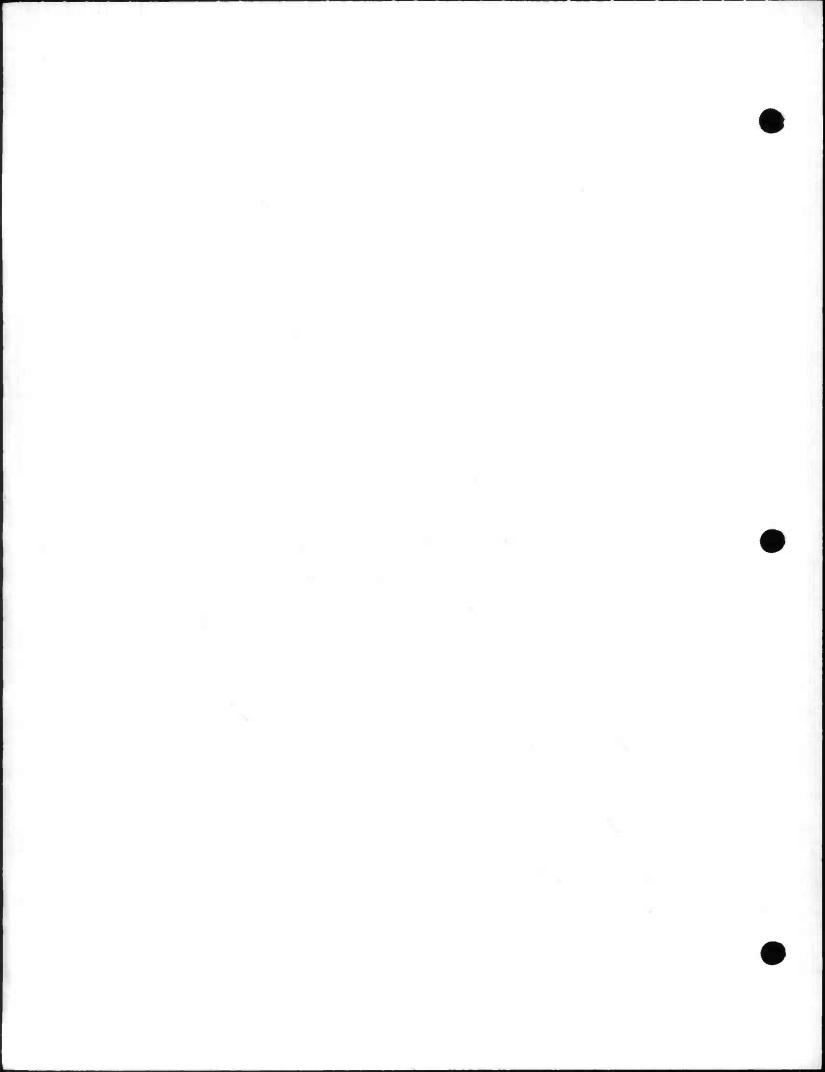
1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	REGISTRAR		CENT	ILIC	AIE OF	DEATH	A	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) Flizabeth Kathleen Lafton 2. DATE OF D MONTH						DEATH DAY YEAR 3. TIME OF DEATH 4 1995 5:15 Pm				
	4. SOCIAL SECURITY NUMBER	AGE (in yrs. last birth			JULY						
J	576-18-6665	82 YR	MON	ITHS DAYS	HOURS MIN.	June	June 8, 1913		8. BIRTHPLACE (State or Foreign Country) Hawaii		
	9e. FACILITY NAME (If not institution, give	street end number)		9b.	CITY, TOWN	R LOCATION OF D	EATH		9c. COU	NTY OF D	EATH
8	13612 Voland Court				Dayto	n			How	ard (County
DIRECTOR	RESIDENCE OF DECEDENT				-4						
2	10a, STATE 10b, COUN			CITY, TO	WN OR LOCAT	ION					10d, INSIDE CITY LIMITS?
	Maryland Howard County				Dayton						1 YES 2 1
AL	10e. STREET AND NUMBER				101	. ZIP CODE		10g. CITIZEN OF WHAT COUNT			WHAT COUNTRY?
FUNERAL	13612 Voland Court				21036			USA			
5	11. MARITAL STATUS	12. WAS DECEDENT EV	ER IN U.S. ARMED		13. WAS DEC	ENDENT OF HISPAI	NIC ORIGIN? (S	pecify Yes	or No-	14. RACE	- American Indian, t, White, etc.
ΒĄ	1 ☐ Never Married					22 MO Specif		1; etc.)		Specify: MIXed	
COMPLETED	15. DECEDENT'S ED! (Specify only highest grad		16e. DECEDER	NT'S USU	AL OCCUPATION	ON st of working	16b. KIN	D OF BUS	INESS/IND	USTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do No	OT use ret	done during mo ired.)	or working					
M P	12		sales				re	tail			
ᅙ	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First, Middl	e, Maiden S	Sumame)		
BE	Raymond Ros	ario				Mati1	da Coc	kett			
0	19e. INFORMANT'S NAME (Type/Print)		19b. MAII	LING ADD	PRESS (Street e	nd Number or Rural	Route Number, C	lity or Town	, State, Zip	Code)	
=	Mr. Reid M. Loft	on	136	512 V	Voland	Court,	Dayton	, Ma:	ry1a	nd 21	1036
ŀ	20a. METHOD OF DISPOSITION 1 ☐ Buriel 2 ☐ Formation 3 ☐ Rer	novel from Care	20b. PLACE AND DA	ATE OF DI	SPOSITION (Ne			_	CATION —		
	4 Donetion 5 Other (Specify)	novali from State	Baltimore	Vash	ingtan (rematory '	7-6-95	Li	aure	L. Ma	aryland
	21. SIGNATURE OF FUNERAL SERVICE L	CENSEE /			22. NAME AN	D ADDRESS OF FA	CILITY				
	Chlundeller	Sleet	MOC	535		lack Fun llicott					13
O BE COMPLETED BY PHYSICIAN: MEDICAL CENTIFICATION	shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions. DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not bate determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WATER CONTROL OF THE CONT	YES [DEATH (CO A 4 T TIME OF INJURY TIME OF INJURY TO THE OF INJURY TO THE OF INJURY TO THE OF INJURY TO THE OF INJURY TO THE OF INJURY	e underlying NO Deck only gle) NER: Nursing Hom 28c. INJ WO 1 U , factory, office The time, date my opinion, d	UNCERTAIN P 5 Residence PR AT RK? ES 2 NO end place, end due path occurred at the 29c. LICENSE NUM 272	Part I. 24a 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	N (Street er	JURY OCCURATION OF THE STATE OF	or Rural Ri			
	JUL 1 0 1995	hi detalland	SIGNATURE								
	7										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM	ENT OF HEALTH AN	D MENTAL HYGIE		
	1. DECEDENT'S NAME (First, Middle, Les)	· Lutz	24	, ř _j ,	2. DATE OF DEATH	W 03.19	3. TIME OF DEATH 7:00P M
	4. SOCIAL SECURITY NUMBER 191-44-4728 99. FACILITY NAME (If not institution, give a	1 □ M 2 💢 F 41	YRS. MONT		(Month, Day, Year) SEPT. 15	1953 P	BIRTHPLACE (State or Foreign Country) PENNSYLVANIA
CTOR	North Aru RESIDENCE OF DECEDENT	indel Hos	pital	GIRA BU	unie	Ann.	e Arundel
- DIRECTOR		E ARUNDEL		NN OR LOCATION ASADENA		34	10d. INSIDE CITY LIMITS? 1 VES 2 NO
FUNERAL	254 WHITAKER ROAD			101. ZIP CODE 2112	22.		USA
BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN I FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 (X) NO	13. WAS DECENDENT OF HIS If yes, specify Cuben, Me 1 YES 2 NO Sp	xican, Puerto Rican, etc.)		RACE American Indian, Black, White, etc. Specify: WHITE
COMPLETED	15. DECEDENT'S EDU (Specily only highest grade Elementary/Secondary (0-12) 12	CATION completed) College (1-4 or 8+)	16a. DECEDENT'S USUA (Give kind of work d life. Do NOT use retir HOMEMAK	one during most of working ed.)		OUSEHOLI	
BE CO	17. FATHER'S NAME (First, Middle, Last) ROBERT AUGUSTYNI.	AK		18. MOTHER'S GLADY	S V. FAGER	n Sumama) STROM	
5	EDWARD E. LUTZ,	JR.		TAKER ROAD,			
	29a. METHOD OF DISPOSITION 1 A Burlet 2 Cremation 3 Rem 4 Donation 6 Other (Specify)	coval from State comet	PLACE AND DATE OF DIS PLACE AND VE	TERANS CEMETI	ERY 7-6 C	ROWNSVI	
	21, SIGNATURE OF FUNERAL SERVICE LIC	LINGS AR	1.7	22. NAME AND ADDRESS OF STALLINGS F 3111 MOUNTA	UNERAL HOMI	E, P.A.	
CERTIFICATION	23. PART I. Enter the diseases, or a shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO	CONSEQUENCE OF): CONSEQUENCE OF): CONSEQUENCE OF): CONSEQUENCE OF): CONSEQUENCE OF):	Final	such as cardiac or rea	piratory arrest,	Approximata interval Between Onset and Daeth Slays
PHYSICIAN: MEDICAL CE	PART II. Other significant condition				PEAFO 1 YES	IN AUTOPSY DRMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
CIAN	DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	28 HOSPITAL:	PLACE OF DEATH (Ch		AIN 🗷		
	1 VES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pending	1 Inpatient 2 ER/Outpati		Nursing Home 5 Residen 28c. INJURY AT WORK?	ce 6 Other (Specify) 26d. DESCRIBE NOW	INJURY OCCURE	D
LED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — building, atc. (Specify	- At home, farm, street,	1 YES 2 NO	28f. LOCATION (Street City or Town, State	and Number or Ri	ural Route Number,
COMPLE		CIAN: To the best of my knowled					
O BE CO	296. SUMATURE AND TITLE OF CERTIFIER	Hending Ph	YSICIAN	29c. LICENSE I			MED (Month, Day, Mar)
	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DEAT	Hospital	Dr. Glen Bu	rnie, Md. 2	1060	1
	1111 1 0 1995	distribute Signat	UNE				



DIVISION OF VITAL RECORDS, P.O. BOX 68760

0100 C: 1:1 C: C: C: C: C: C: C: C: C: C: C: C: C:	24 hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	the medical examiner must be notified at once.
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	CATE OF	DEATH	Ri	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) MARY (MARION) CA	ATHERINE MAR'	rtn			2. DATE OF D	EATH DAY		AR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		(in yrs. last birthday)	IF UNDER 1 YEAR	# 1800mm at 1800	JULY 8,			95	1:00 P.M
	218-14-2629	1 M 2 X F 83		MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	JAN . 12	: Year)		Country,	TO., MD
OR	9a. FACILITY NAME (If not institution, give s 430 MILLINGTON AV		96. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH BALTIMORE CITY			
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	v	1 40 - 0170						_	
DIRECTOR	MARYLAND BALT	TIMORE CITY	10c. CIT1	r, town or locat BAI	LTIMORE				- 1	10d. INSIDE CITY LIMITS? 1 X YES 2 NO
FUNERAL	430 MILLINGTON AV	VENUE		101	21223				OF WI	HAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 XWidowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 XNO	If yes, sp	ENDENT OF HISPAN ecity Cubers, Mexican 2 NO Specify	n, Puerto Rican,	ecify Yes o , etc.)	r No 14,	RACE	- American Indian, White, etc.
	15. DECEDENT'S EDU (Specify only highest grade	CATION	16s. DECEDENT'S	USUAL OCCUPATION OF COMPANY	DN	16b. KIND	OF BUSIN	NESS/INDUST	RY	WHITE
COMPLETED	Elementary/Secondary (0-12) 8TH GRADE	College (1-4 or 5+)	HOMEMAK	e retired.)	st of worlang		н	OMEMAK	TNO	2
Š	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAI	ME (First, Middle				
BE	JOHN OGLE 190. INFORMANT'S NAME (Type/Print)		T		ELIZAE			KNOWN)		
2	MRS. BARBARA McKE	ĽΕ			nd Number or Rural F					21223
	20a, METHOD OF DISPOSITION 1 Parial 2 Cremation 3 Rem	cval from State cen	D. PLACE AND DATEO	F DISPOSITION (Na	me of	DATE		TION — City		
	4 Donation 8 Other (Specify) 21. SIGNATURE OF FUNEHAL SERVICE LIC	LO	OUDON PAR	K CEMETE	CRY ID ADDRESS OF FAC	7/12	BAl	LTIMOR	E	
	Jackie W	. Shans	non	HUBBAR	RD FUNERA	L HOME			МТ	21229
	23. PART/ Enter the diseases, proshock, or heart fellure.	complications that caused List only one cause on a	d the death. Do n	ot enter the mo	de of dying, such	as cardiec	or reapira	tory arrest,		Approximate interval Between
	iMMEDIATE CAUSE (Final disease or condition resulting in death)	" Probable		u Asy	Thinis of Selevot	1/4 P	pyve	mha	2	Onset and Death Suggles
NO	Sequentially list conditions,	h Hyper	A CONSEQUENCE OF		Februat	e Car	hov	As and	'n	- Seven
CATI	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	e Or in (on as a	CONSEQUENCE OF):			D	r Sea		geny
CERTIFICATION	thet initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):						
	PART ii. Other significant condition	s contributing to death b	out not resulting in	n the underlying	cause given in i	Part i. 24a.	WAS AN AL		24b. \	WERE AUTOPSY FINDINGS
EDICAL						_ 10	YES 2	,		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
Z Z	DID TOBACCO USE CONTI	RIBUTE TO CAUSE C	F DEATH YES	S NO	UNCERTAIN	1 🛛			1	1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	H (Check only one)						
17S	1 YES 2 K NO	1 Inpetient 2 ER/Outp	patient 3 DOA	4 - Nursing Home	/-					
ВУ РЕ	1 Natural 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	OF 28c, INJU JRY WO	RK?	28d. DESCRIB	E HOW INJ	URY OCCURE	D	
	3 Suicide 8 Could not be determined	28a. PLACE OF INJURY building, atc. (Spec	— At home, ferm, st cify)	ireet, factory, office		281. LOCATION City or Tow	(Street and m, State)	1 Number or R	ural Ro	ute Number,
COMPLET		CIAN: To the best of my know							100(0) 1	and manner as stated.
H	296. SIGNATURE AND TITLE OF CERTIFIER	Kahma	nus		29c. LICENSE NUM	403	3 2	Pad. DATE SIG	NED (I	Month(Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO							-/-	1	
	DR. ARIQ UR RAHMA 31. DATE FILED (Month, Day, Year)	N - 716 MAID	EN CHOICE	E LANE -	SUITE-L	L-1 - (CATON	SVILL	Ε,	MD 21228
	JUL 1 01995 A	in alludion had	tall							

DIVISION OF VITAL RECORDS, P.O. BOX 68760

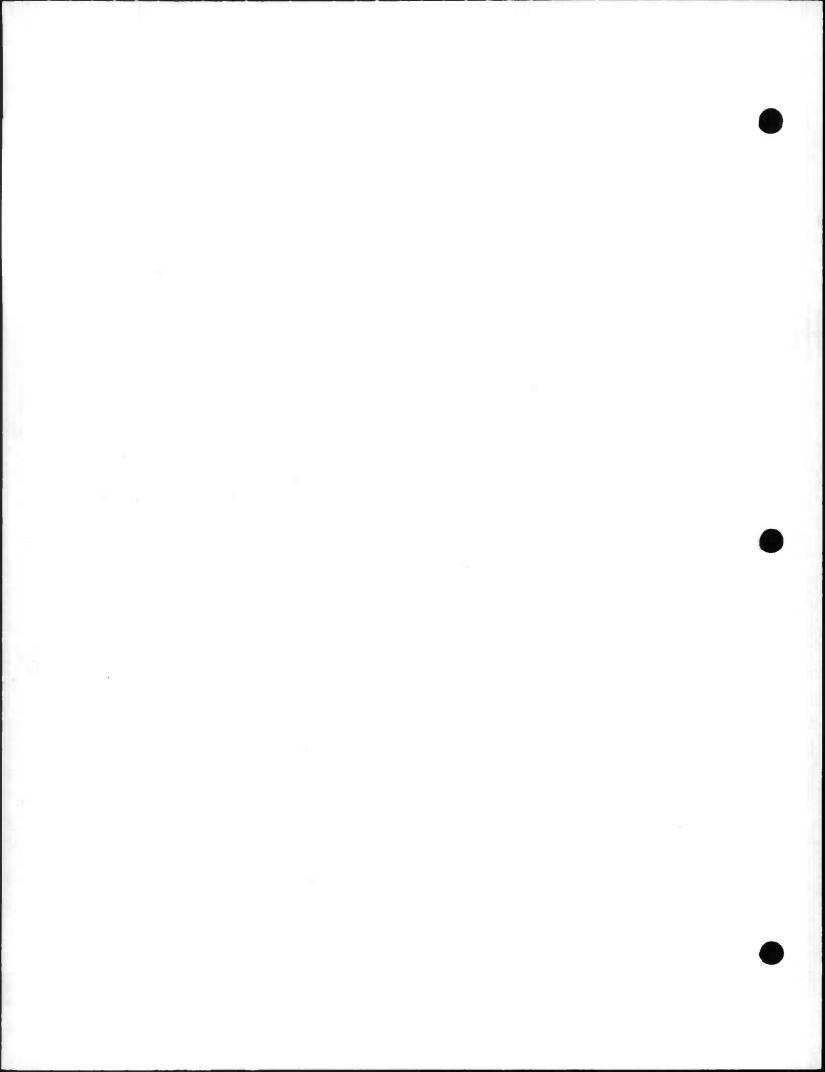
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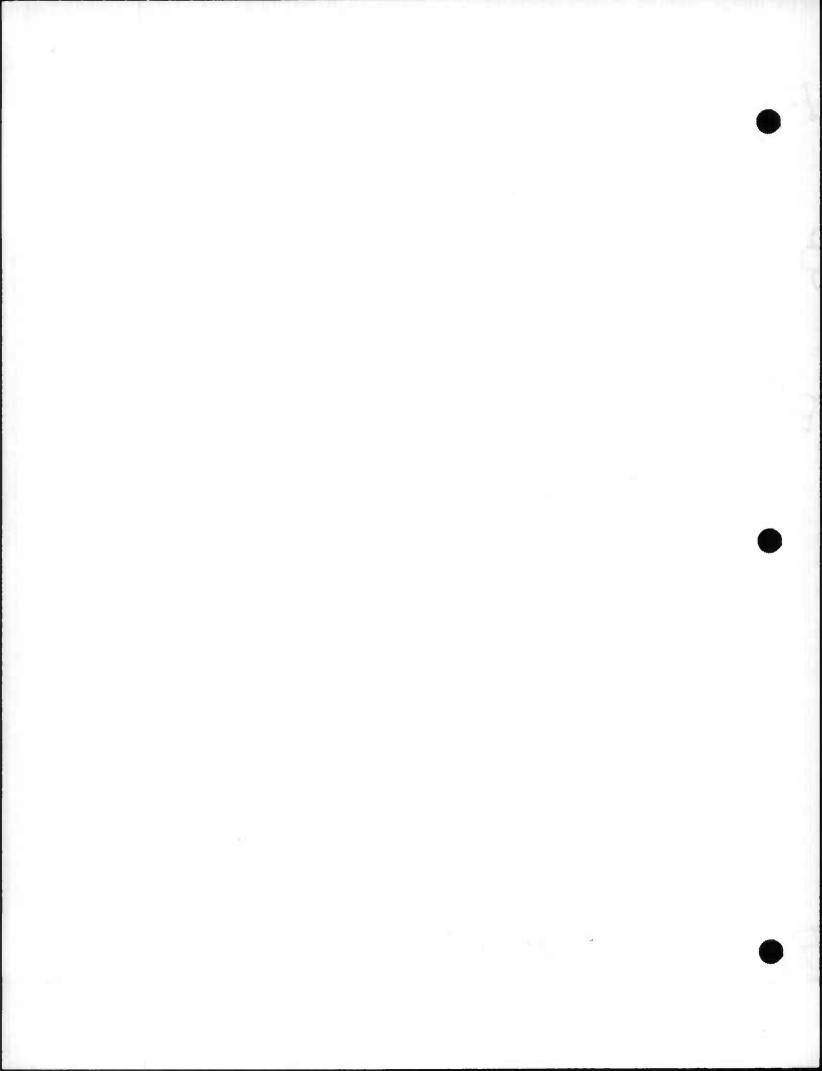
1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR			<u> </u>	-1111	ICALE	UF	DEA			REG. NO.			
9	1. DECEDENT'S NAME (First	, Middle, Last)	James H	. Mitch	e11 .	Jr.				2. DATE MONTH	OF DEATH	AY 1	995	3. TIME OF DEATH 9:25 P. M
	4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. les	t birthday)			IF UNDER		7. DATE	OF BIRTH	6. BIRTHPLACE (State or Foreign Country)		
	214 16 8489 1 △ M 2 □ F 72					MONTHS	Dec. 9, 1922 Mary				yland			
œ	9a. FACILITY NAME (If not Institution, give street and number) 24 Thomas Avenue							OR LOCATI	ON OF DE	HTA			INTY OF DE	
DIRECTOR	RESIDENCE OF DECEDENT					Baltimore					Ani	ne Ar	undel	
2	Maryland	10b. COUNT		1	400	Y, TOWN C		TION						10d. INSIDE CITY LIMITS?
_	Maryland 104. STREET AND NUMBER		ne Arunde	.T	Ba	altin								1 TES 2 X NO
RA	24 Thomas		1e				101	2IP COD	225					HAT COUNTRY?
FUNERAL	11. MARITAL STATUS			T EVER IN U.S. AR	MED	13. 1	WAS DEC	ENDENT O	OF HISPAN	IIC ORIGIN	? (Specify Yes		U.S.A	- American Indian
B	1 Never Merried 2 🔀 3 Widowed 4 Dive		IF YES, GIVE Y	MAR OR DATES WAL II	10	1 3	f yes, sp	ecify Cuba 2 X NO	in, Maxicai	n, Puerlo P	licen, etc.)		Black Specifi	White, etc.
	15, DEC (Specify onl	EDENT'S EDU y highest grade	CATION completed)	16a. DE	CEDENT'S	USUAL Of work done of se retired.)	CUPATIO	ON st of working	ng	16b.	KIND OF BUS	SINESS/IN	DUSTRY	
COMPLETED	Elementary/Secondary (0)-12)	College (1-4 or 5	,	orema						Const	ruct:	ion	
3	17. FATHER'S NAME (First, M		James H.	Md L = 1 - 1 -	C			16. MOTI			fiddle, Maiden			
m m	19a. INFORMANT'S NAME (1		diles H.								uise I			
2	Alice E.	Mitche				OMas					er, City or Town			21225
	20e, METHOD OF DISPOSIT 1	ION on 3 - Rem (Specify)	oval from State	20b. PLACE A		ss Ce	mete	ery		7/1	0 Bai	Ltimo	or Tow	Marvland
	21. SIGNATURE OF FUNERA	L SERVICE LIC	CENSEE		1	22. I	NAME AN	O ADDRE	SS OF FAC	CE FI	neral	Home	0 D 7	
	John	N/1	Sorani	usur	ski	40	001	Ritc	hie 1	Hwy.	Balt	imor	e. Md	21225
	23. PART I, Enter the di shock, or h	lsasses, or a	complications the	t caused the da	ath, Do i	not antar	tha mo	de of dy	ing, such	n ss card	lac or respi	retory sr	reat,	Approximats Interval Between
	IMMEDIATE CAUSE (Fir disease or condition	ial	/	11100	/	1 40	'. سـ ،		M	1				Onset and Death
	resulting in dasth)	→	S. DUE TO	OR AS A CONSEC	UENCE O	FI:	4	\sim $^{\circ}$	110					13 mt
z	#21227-1012 No. 2012		b	Em	DA:	750	5M	1						
AT 10	Sequentially list conditi if any, leading to imme- cause, Entar UNDERLY	diata	DUE TO	(OR AS A CONSEC	DUENCE O	F):								
FIC	CAUSE (Disease or inju		c	(OR AS A CONSEC	UENCE O	F):								
CERTIFICATION	resulting in death) LAS	T (d											
EDICAL (PART II. Other significa	nt condition	s contributing to	death but not n	esuiting	in the un	dariying	cause o	given in I	Part I.	24s, WAS AN PERFOR			WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
EDIC										_]	1 YES 2	THO		COMPLETION OF CAUSE OF DEATH?
Σ	DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF DEA	TH YE	S \square N	JO [LINC	EDTAIN		•			1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?					TH (Check o		0110	EXIAII		-			
YSIG	1 TES 2 1 40		HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER 4 Nurs	t: ing Hom	5 D-16	aldence	6 🗆 Other	(Specify)			
	27. MANNER OF DEATH 1 Netural 5	Pending	28a. DATE OF (Month, D.	INJURY ny, Year)	28b. TIM INJ	E OF IURY		RK7		28d. DES	CRIBE HOW II	NJURY OC	CURED	
ВУ	2 Cutate	Investigation	28e. PLACE O	F INJURY At hor	ne, tarm, r	street, facto		ES 2	NO	28f LOCA	TION (Street a	and Number	r or Rural Ro	urto Mumbar
TED		Could not be datarmined	building,	atc. (Specify)					- 1	City o	r Town, State)		0. 1.0.0.1.0	ere reurissa,
COMPLET			CIAN: To the best of											
	29b. SIGNATURE AND TITLE			amination end/or i	westigatio	on, in my o	pinion, d				and place, and			end manner ea stated.
BE	TO SOUND THE	Or CERTIFIER	1/1/1	Theren	-			29c. LICE	NSE NUM	BER 3		29d. DAT	SIGNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF	PERSON WH	O COMPLETED CAUS					w 2		00				//
	ASH	BKK	CHA	THEN			3	927	7, 1	ANA	APO	213	R	Month, Day, Year) 7-95 74) 21227
	31. DATE FILED (Month, Day,		1.	R'S SIGNATURE										
	JUL 1 0 19	35 A	d'aude	charlet										
														DHMH-16 Rev 1/89



PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	APORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law require	TO THE FUNERAL DIRECTOR; After this certificate has been sig be filed within 72 hours after death with the State Dept, of He.	IMPORTANT: If item 28 is marked, or item 23 shows	

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI			MENTA	L HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last) BERNARD	М	AJERON			2. DATE MONTO TUL	OF DEATH	- 1995	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 219-14-2205	5. SEX 6. AGE (In yrs. last birthday) FUNDER 1 YEAR FUNDER 24							
TOR	9a. FACILITY NAME (If not institution, give s GOOD Samaritan F RESIDENCE OF DECEDENT		timore	DEATN /A					
DIRECTOR	10a. STATE 10b. COUNTY Maryland	v N/A		OWN OR LOCAT					10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	3903 E. Jopp	oa Rd. Apt.			21236			USA	WHAT COUNTRY?
B⊀	1 Never Married 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 YES	2 NO	If yes, sp	ENDENT OF HISPA lefty Cuban, Maxic 2 X NO Speci	en, Puarto I	i? (Specify Yea or Ricen, atc.)	Soi	CE — American Indian, ct., Whita, etc.
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 12th.	CATION completed) College (1-4 or 5+)	16a. DECEDENT'S US (Give kind of work life. Do NOT use re	done during mo stired.)	st of working		KIND OF BUSIN		
BE COM	17. FATHER'S NAME (First, Middle, Last) Jim Maje	erowicz	HVAC Su	perviso	16. MOTNER'S NA	AME (First, I	S. GOV Middle, Meiden Sur ROGOW	meme)	t
TO B	19a. INFORMANT'S NAME (Type/Print) Mary R. Majerow	vicz			nd Number or Rural	Route Numb	per, City or Town, S	State, Zip Code)	Md. 21236
	20a METHOD OF DISPOSITION 1 A Burtel 2 Cremation 3 Remid 4 Donation 5 Other (Specify)	Ge	PLACE AND DATE OF CONTROL OF CONT	Faith C	emetery		20c. LOCA 1 Bail	timore	own, State , Maryland
	* Lavil	Mile		David 401 S	J. Webe Cheste	er Fu er St	. Balti	more,	Maryland 2123
	IMMEDIATE CAUSE (Final	complications that couse that couse that couse on e cau	ach line.						Approximata interval Batween Onset and Death 2 weeks
CERTIFICATION	Sequentielly liet conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	eding to immediate nter UNDERLYING Disease or injury ated events OUE TO (OR AS A CONSEQUENCE OF):							
ÄL	PART II. Other significent condition					Part I.	24a. WAS AN AU PERFORME 1 YES 2	:0?	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONTR		F DEATH YES			N 🗆			1 - YES 2 - NO
YSICI	EXAMINER? 1 VES 2 NO	HOSPITAL:	etlant 3 DOA 4	THER: Nursing Home	5 - Realdence	6 Other	(Specify)		
ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	26a. DATE OF INJURY (Month, Day, Yeer)	28b. TIME O	M 1 Y			CRIBE HOW INJU		
ETED	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, atc. (Spec	eny)			City o	ATION (Street and or Town, State)		Route Number,
COMPLETED	(Check only 1 CERTIFYING PHYSIC	CIAN: To the best of my know R: On the basis of examination	ledge, death occurred a n and/or investigation, is	t the time, date n my opinion, de	and place, and due ath occured at the	to the cau	ee(a) and manned and place, and d	r as stated. lua to the cause	a) and manner as stated.
TO BE (29b. SIGNATURE AND TITLE OF CERTIFIER	upiso	M.D		PO 8		29	od. OATE SIGNE	(Month, Day, Year)
-	30. NAME AND ADDRESS OF RERSON WHO MAYA GU 31. DATE FILED (Month, Day, Year)	PTA	GOOD		IARITA.	N	Hos	SPITA	L
	JUL 1 0 1995	32 REGISTRAR'S SIGN	Hall						



BALTIMORE, MARYLAND 21215-0020	urs after death. Page 6 may be retained by the hospital or attending physici	in by the funeral director, page 5 should be detached for use as the burial-
DIVISION OF VITAL RECORDS, P.O. BOX 68760	. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physics	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-
2	. OR /	DIRE

e burial-transit permit. Pages 1, 2, 3 should g physician. item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing. hours after a TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and competely filled in by the be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burlal, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatte event. The medical a

BE COMPLETED BY FUNERAL DIRECTOR

2

PHYSICIAN: MEDICAL CERTIFICATION

BY

COMPLETED

BE

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FOR STATE REGISTRAR		STATE OF MAR	YLAND C	/ DEPARTM	MENT OF	HEALTH AND N	MENTAL HYGIEN			
1. DECEDENT'S NAME (First,	nesw = 1	McSwee	_ n e	4			2. DATE OF DEATH	MY	195	3. TIME OF DEATH
375 ≈ 16 ≈ 9419 90. FACILITY NAME (# not in	ĘR	5. SEX 6. A	GE (In yrs. I	est birthday) IF MO	NTHS DAY	B HOURS MIN.	7. DATE OF BIRTH (Month, Day Year)		West	Virginia
Northwest Ho	spita			91		n or Location of DE. Candallstow			altim	
Maryland	10b. COUNT	imore			own or Lo	CATION Mills				10d. INSIDE CITY LIMITS? 1 YES 2 NO
10902 Hunto	liff	Drive				10f. ZIP CODE 21117			S.A.	HAT COUNTRY?
11. MARITAL STATUS 1 Never Merried 2 2 3 Widowed 4 Divo		12. WAS OECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR O	ES 2	MED	If yes,	PECENOENT OF HISPANI apecify Cuban, Mexican /ES 2 NO Specify:	, Puerto Rican, etc.)	e or No-	Black.	- American Indian, White, atc. White
	EDENT'S EDU highest grade -12)			ECEDENT'S USI Give kind of work le. Do NOT use re	done during etired.)	ATION most of working	16b. KIND OF BU	memal	DUSTRY	
17. FATHER'S NAME (First, Mi	Ashw	orth				Hester	Ann Spurl	ock		
Hester Price		_	1	96. MAILING AD 2204 01	oness (Street	et and Number or Aural A tminster F	oute Number, City or Tox	m, State, Zip Bburg	Code)	21048
20a. METHOD OF DISPOSITI 1 Burlel 2 Crematio 4 Donation 8 Other	n 3 🗆 Rem (Specify)			eand oate of d rematory or other Crema			1995 Ba	CATION —	City or Tow	rn, State
21. SIGNATURE OF FUNERAL	#4 8	Eshads			Eckh 1160		al Chapel	Owing		lls, MD.2111
23. PART I. Enter the di ahock, or he IMMEDIATE CAUSE (Fin disesse or condition	est fallure.	List only one ceuse o	n each lin	ie.		mode of dying, such	sa cerdisc or reep	iratory sm	reat,	Approximate interval Between Onset and Death
resulting in death)	+			Stole		1				
Sequentially list conditi if any, leading to immed cause, Enter UNDERLY!	diete NG	b. DUE TO (OR A	Les A CONSI	EOUENCE OF):	Hyn	· vent.	atim (1 0	
CAUSE (Disease or Inju-	ry 1	DUE TO (OR A	S A CONSI	EQUENCE OF:				1~	er 6	

that initiated events resulting in deeth) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i.

DUE TO (OR AS A CONSEQUENCE OF):

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 24s. WAS AN AUTOPSY 1 | YES 2 |-NO 1 | YES 2 | NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL

HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA Home 5 ☐ Residence 6 ☐ Other (Specify)

28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK?
1 YES 2 NO 26b. TIME OF INJURY

28d. DESCRIBE HOW INJURY OCCURED 28e. PLACE OF INJURY — At home, farm, atreet, fectory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29c. LICENSE NUMBER

29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(e) and manner as stated.

2 __ MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end manner ee stated.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

D271 50 MA .~ STrut

7/2/ Rente

29d. DATE SIGNED (Month, Day, Year)

n 1)

31. DATE FILED (Month, Day, Year) 0 1995

29b. SIGNATURE AND TITLE OF CERTY

1 YES 2 NO

5 Pending

8 Could not be

27. MANNER OF DEATH

1 Natural

2 Accident

3 Suicide

4 🔲 Homicide

32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

2114

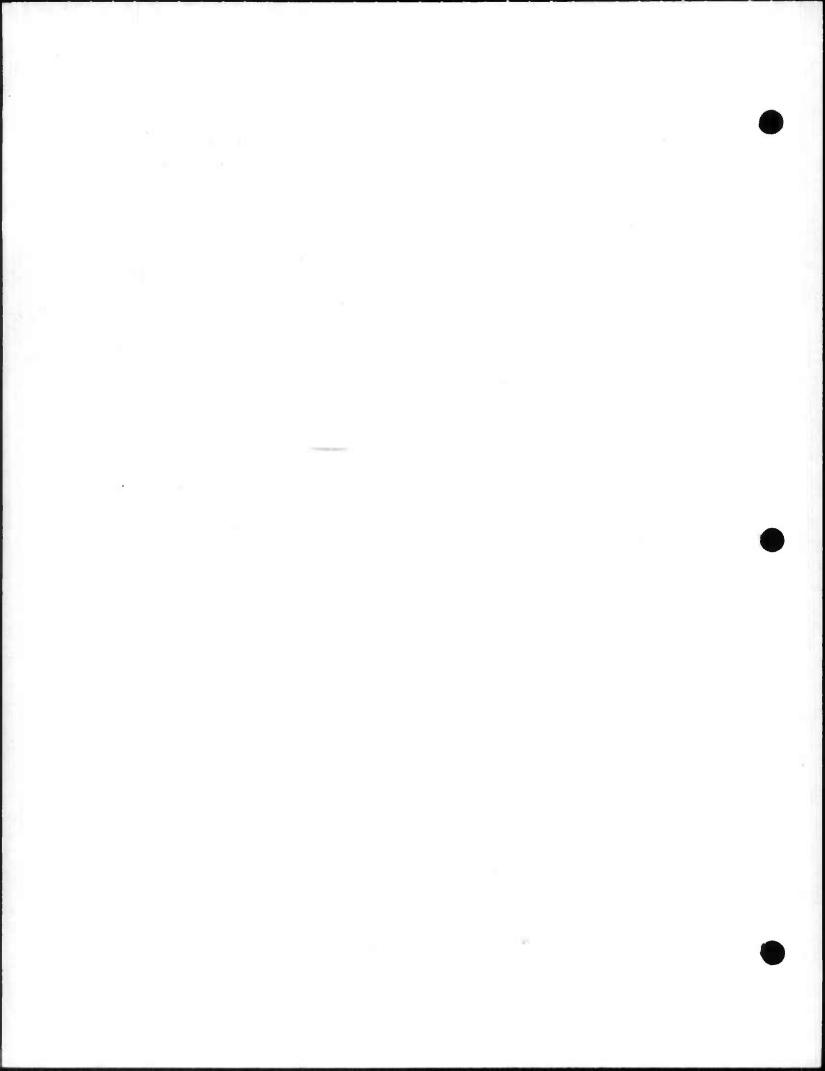
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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To hou	filled in	ion, or
G PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	npletely	cremat
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certific	ding ph	Нудіеле
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requires	en sign	of Heal
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ENDING	JR: Afte	ter deat
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SPITAL	NERAL	hin 72 1
THE HOSPITAL OR ATTENDING PH	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit	filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial,
		-

2, 3 should

	FilmG, 725, item #20%	7/10/05 (77)	non 6 h	95	20794
		MARYLAND / DEPARTME	~	MENTAL HYCIPAE	
	1 - STATE STATE OF		TE OF DEATH	REG. NO.	
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH MONTH DAY	3. TIME OF DEATH
	ACQUANETTA V.	MAULTSBY		JULY 3 199	
	4. SOCIAL SECURITY NUMBER 5. SEX 71(0-52-4057 1 0 M 2 X)		HOER 1 YEAR IF UNDER 24 HRS. HS DAYS HOURS MIN.	(Month, Qay, Year)	BIRTHPLACE (State or Foreign Country)
	9a. FACILITY NAME (If not institution, give street end number)	172	CITY, TOWN OR LOCATION OF OE	April 5, 1950	MD
E			BALTO		Y OF DEATN
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY				
DIRECTOR	A M D		LTIMBLE		10d. INSIDE CITY LIMITS? 1 YES 2 NO
A L	10s. STREET AND NUMBER	1 1 1 1	10f. ZIP CODE	10g. CITIZE	N OF WHAT COUNTRY?
FUNERAL	903 Druid Park	Lake HR. 5A	+ 21217	U.S.	SiA-
	II 1 I MANAGE MARTINGS	PENT EVER IN U.S. ARMED 1 YES 2 NO E WAR OR DATES	13. WAS DECENDENT OF NISPAN If yes, specify Cuben, Mexicar	, Puerto Ricen, stc.)	4. RACE — American Indian, Black, White, etc.
BY	3 Widowed 4 Divorced	: WAR OR DATES	1 TES 2 NO Specify		Specify: Black
E	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	18e. DECEDENT'S USUAL (Give kind of work do	one during most of working	16b. KIND OF BUSINESS/INDUS	STRY
COMPLET	Elementary/Secondary (0-12) College (1-4 or	5+) Iffe. Do NOT use retired		lau losse	s. FAST FOOD
OM	17. FATNER'S NAME (First, Middle, Last)	LITANA		IE (First, Middle, Maiden Surname)	2.147(100P
BE C			KATHE	FRINE	
5		19b. MAILING ADDRI	ESS (Street end Number or Rural R	oute Number, City or Town, State, Zip C	000)
	Q0a, METHOD OF DISPOSITION	20b. PLACEAND DATE OF DISP	POSITION (Name of	DATE 200 LOCATION - CH	No P Town State
	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	King Mellion id	1 Aptr Park		stown, Md
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FAC		
	- Dunes	- Scott		WEST 4300 WAR	
	23. PART I. Enter the diseases, or complications to shock, or heart fallure. Liet only one of	hat caused the death. Do not entrause on sech line.	ter the mode of dying, such	as cerdiac or respiratory arres	t, Approximate interval Between
	IMMEDIATE CAUSE (Final disease or condition			_	Onset and Death
1	resulting in death) e. HCQ	U (RED IMMU TO (OR AS A CONSEQUENCE OF):	NODETCHEN	ey syndrou	to 3 yaus
z	- II	LAN MULLINOTO (OR AS A CONSEQUENCE OF):			
15 15	Sequentially list conditions, if any, leading to immediate	TO (OR AS A CONSEQUENCE OF):	277-10-10-0	1.0[
2	CAUSE (Disease or Injury	TO (OR AS A CONSEQUENCE OF):			
ERTIFICATION	that initiated events resulting in death) LAST	to (on as a consequence or):			
0					
MEDICAL	PART II. Other significant conditions contributing	to death but not resulting in the	underlying ceuse given in i	Part I. 24s. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
ED				1 □ YES 2 1 40	OF DEATH?
×	DID TOBACCO USE CONTRIBUTE TO C	AUSE OF DEATH YES	NO UNCERTAIN		1 TYES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATN (Che			
YSIC	1 YES 2 NO 1 Inpatient	ER/Outpatient 3 DOA 4 N	IER: Nursing Home 5 N Residence (Other (Specify)	
		OF INJURY 26b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCU	RED
B	2 Accident Investigation	OF INJURY — At home, ferm, street, fi	1 VES 2 NO		
		ig, etc. (Specify)	ractory, ornice	28f. LOCATION (Street and Number or City or Town, State)	Rural Route Number,
1 2	3 Suicide 6 Could not be 4 Homicide determined				
PLETE	3 Suicide 6 Could not be determined 28e. PLACE buildir 29e. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best		ne time, date end place, end due t	o the causele) and menner se stated	
OMPLETE	3 Suicide 6 Could not be determined 28e. PLACE buildir 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of	of my knowledge, death occurred at the			
E COMPLETED	4 Homicide determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beele of the control of the beele of the control of the beele of the control of the beele of the control of the beele of the control of the beele of the control of the beele of the control of the beele of the control of the control of the beele of the control of the co	of my knowledge, death occurred at the		ime, date and place, and due to the o	
	4 Homicide determined building 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basic of the basic	of my knowledge, death occurred at the seamination end/or investigation, in my	ny opinion, death occured at the t	ime, date and place, and due to the o	euse(e) end menner ee stated.
BE	4 Homicide determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beele of CERTIFIER AND TITLE OF CERTIFIER	of my knowledge, death occurred at the standard of examination end/or investigation, in my control of the standard of the stan	29c. LICENSE NUM	BER 29d. DATE S	euse(e) end menner ee stated.
BE	4 Homicide determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beet of the best one) 2 MEDICAL EXAMINER: On the beet of the best one of the best of the bes	of my knowledge, death occurred at the examination end/or investigation, in me the second of the sec	29c. LICENSE NUM	ime, date and place, and due to the o	euse(e) end menner ee stated.
BE	4 Homicide determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beet of the best one) 2 MEDICAL EXAMINER: On the beet of the best one of the best of the bes	of my knowledge, death occurred at the standard of examination end/or investigation, in my control of the standard of the stan	29c. LICENSE NUM	BER 29d. DATE S	euse(e) end menner ee stated.



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NCIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	finds has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	tic event, th
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fill be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic ev

						95	20795			
	1 - STATE REGISTRAR	STATE OF MARYLAND		NT OF HEALTH AND TE OF DEATH	MENTAL HYGIEN					
FUNERAL DIRECTOR	4. SOCIAL SECURITY NUMBER 2 13 - 30 - 6489 90. FACILITY NAME (If not institution, give street TOHN HOPKIN	SEX 8. AGE (In yrs.	YRS. MONTHS	HER 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN. TY, TOWN OR LOCATION OF E BALTIMOF	7. DATE OF BIRTH (Month, Day, Year) NOV 18, 1	9c. COUNTY	BIRTHPLACE (State or Foreign ourtry) PENNA.			
	10e. STREET AND NUMBER	LTIMORE AUENU		OR LOCATION Odalk 101. ZIP CODE 2122	2		10d. INSIDE CITY LIMITS? 1 □ YES 2 ② NO OF WHAT COUNTRY? \$\int \mathcal{A}\$, \$\mathcal{A}\$, \$\mathcal{A}\$, \$\mathcal{A}\$,			
ВУ	1 Never Merried 2 Merried 3 Widowed 4 Divorced	. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	X) NO	3. WAS DECENDENT OF HISP/ II yee, specify Cuban, Mexic 1 — YES 2 NO Spec	en, Puerto Rican, atc.)		RACE — American Indian, Black, White, atc. Specify: WHITE			
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade con Elementary/Secondary (0-12) C 17. FATHER'S NAME (First, Middle, Last)	oflege (1-4 or 5+)	DECEDENT'S USUAL (Give kind of work don life. Do NOT use retired.	a during most of working AKER	++	OME	RY			
BE		TCHUL	19b. MAILING ADDRE	JUST	AME (First, Middle, Melder NA L Route Number, City or Tov	BEL	ASTOK			
TO	198. INFORMANT'S NAME (Nype/Print) EUGENC MULKANTO 935 DECF PARK RD. WESTMINISTER 2/187 200. METHOD OF DISPOSITION 1 Devial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 200. THERAN TO Name of Completely, Openhard of Completel									
	21. SIGNATURE OF FUNERAL SERVICE LICENS	et Con	relly ?	2. NAME AND ADDRESS OF F. 7110 Solle BALTO. M	O. 2122	y Funes.	AL Home			
	23. PART I. Enter the diseased, or com- shock, or heart fallere. List iMMEDIATE CAUSE (Final disease or condition resulting in death) a	Sepsis	death. Do not enterine.	er the mode of dying, su	ch aa cardiac or reep	Iratory arreet,	Approximate Interval Between Onset and Death			
ERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A CON:								
PHYSICIAN: MEDICAL CE	PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. Congestive heart failure 24a. WAS AN AUTOPSY PERFORMED? 1 YES 24NO 1									
ICIAN:	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1. Yes 2 \(\text{NO} \) NO	28. PL	LACE OF DEATH (Check	k only one)						
BY	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	Inpatient 2 ER/Outpatient 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY — At	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO ctory, office	6 Other (Specify) 28d. DESCRIBE HOW 28l. LOCATION (Street					
COMPLETED	4 Homicide determined 29a. CERTIFIER (Check only) CERTIFYING PHYSICIAN	building, etc. (Specify) To the best of my knowledge, n the basie of examination end/	death occurred at the	time, date end place, end du	City or Town, State;	nner as stated.				
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER SELECTION OF SERVICE AND ADDRESS OF DEPON ADDRESS OF DEPON	ran 1	UD	DZ86	84	29d. DATE SIGN	NED (Month, Day, Year)			

29a. CERTIFIER (Check only	CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(a) and menner as stated
one)	2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the

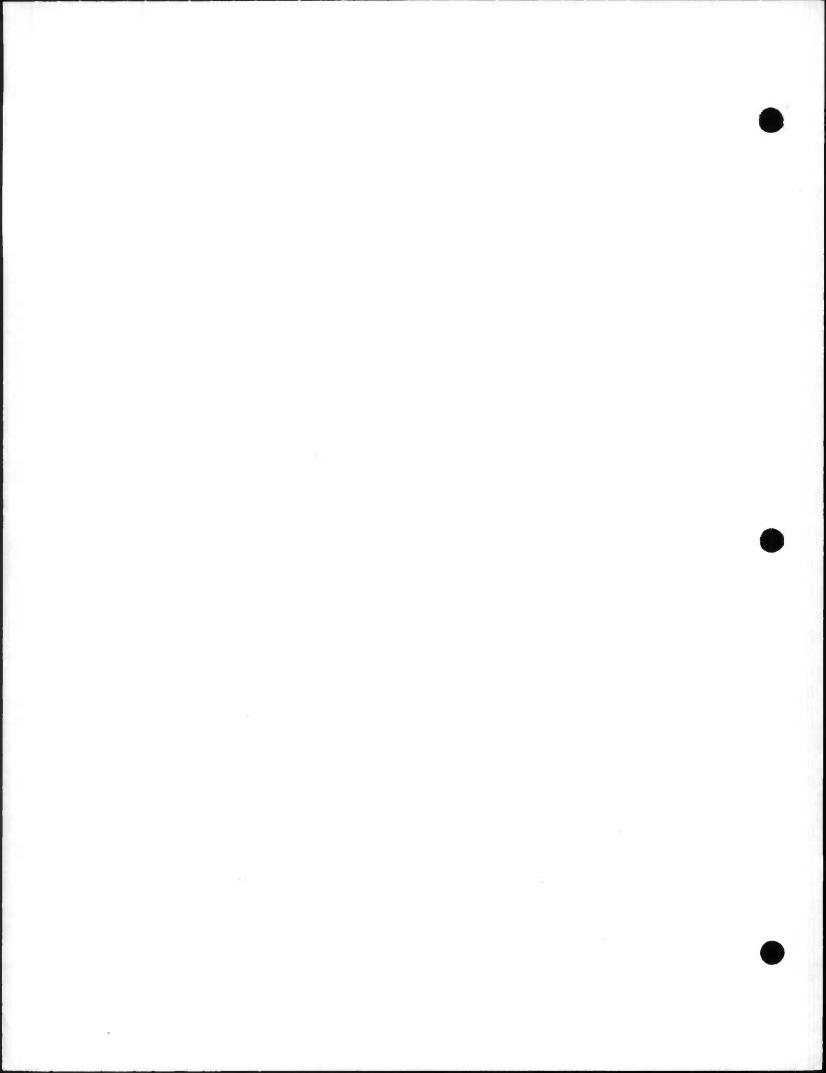
-	-	200		12.50		/-		-	_		-		
0.	NAME	AND	ADDRESS	OF P	ERSOR	WHO	COM	PLETED	CAUSE	OF DEATH	(ITEM 27)	(Type,	Print
_			A .		-					/	1	4	-

31. DATE FILED (MONTH), Day, MAN JUL 1 0 1995 July 3219EG MAN Hopkins / Baywews

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21215-0020	
MARYLAND	
BALTIMORE,	
760	

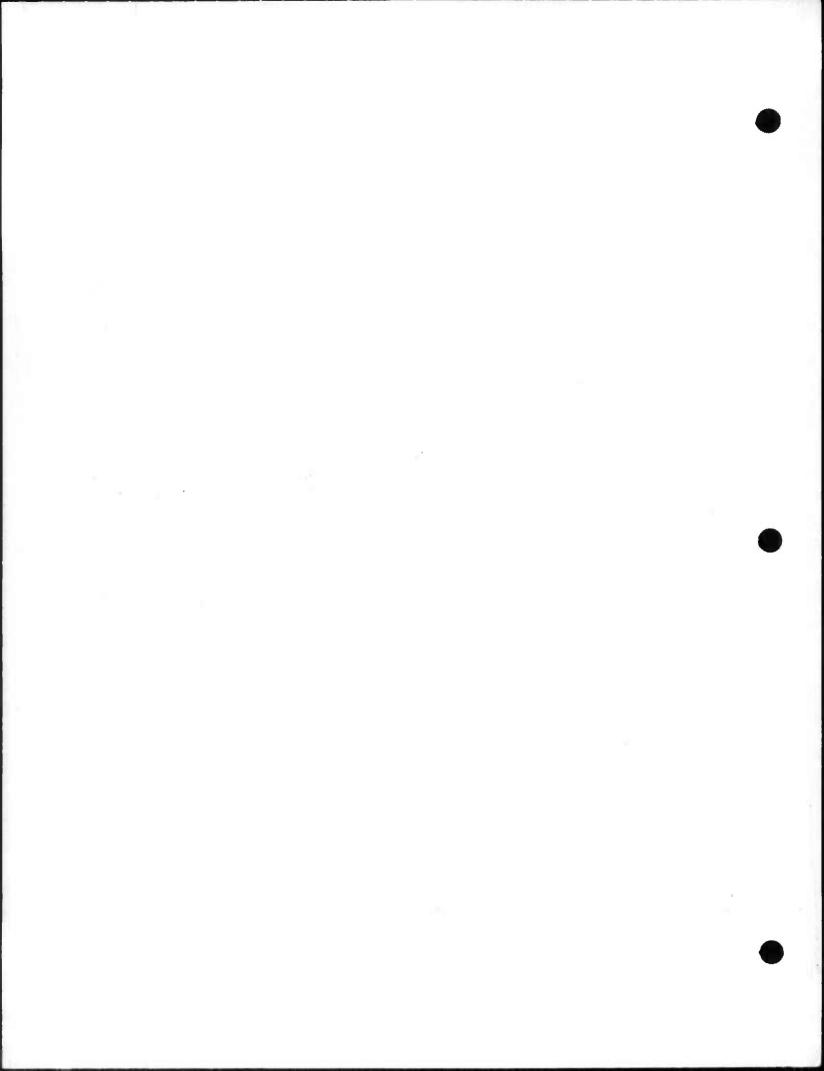
DIVISION OF VITAL RECORDS, P.O. BOX 68:

ifter death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal.	sal examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - FOR STATE REGISTRAR	STATE OF MARYLA		IENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIEN REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DA	V VEAR	3. TIME OF DEATH
3		Molloy, Sr			July 6	1995	
	4. SOCIAL SECURITY NUMBER	1 M M 2 D E	MOI MOI	UNDER 1 YEAR IF UNDER 24 HRS. HTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	Cou	THPLACE (State or Foreign ntry)
	216-18-0908 9e. FACILITY NAME (If not institution, give stre	T - 10		CITY, TOWN OR LOCATION OF D	Danuary 21.	1923	Baltimore
OR	Bayview Medical C			altimore , Cit		N/	
DIRECTOR	100. STATE 10b. COUNTY		OWN OR LOCATION			10d. INSIDE CITY	
DIR	Marvland	N/A	100	timore , Maryla	and		LIMITS?
	10e. STREET AND NUMBER	777	1 Dar	101. ZIP CODE	aria	10g. CITIZEN OF	WHAT COUNTRY?
FUNERAL	4723 Homesdale	Ave.		21206		U.S.	Α.
F	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	13. WAS DECENDENT OF HISPAL If yes, specify Cuban, Mexico	NIC ORIGIN? (Specify Yes	or No 14. RA	CE — American Indian, ick, White, etc.
BY	3 Widowed 4 Divorced	WW 1 1	TES	1 TYES 2 NO Specifi	y:		White
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION	16a. DECEDENT'S USU	IAL OCCUPATION done during most of working	16b. KIND OF BUS		WIIICC
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use rel	lired.)			
OMP	17. FATHER'S NAME (First, Middle, Last)		Customer	<u>Representative</u>			
	Michael E. Mollo	· ·		Mary Ho	ME (First, Middle, Maiden	Sumame)	
) BE	19e. INFORMANT'S NAME (Type/Print)	у	19b. MAILING ADI	ORESS (Street and Number or Rural		n, State, Zip Code)	
2	Mrs. Anna M. Mol	lov		Same as 10e			
	20e. METHOD OF DISPOSITION 1 🔀 Buriel 2 🗆 Cremation 3 🗆 Remove	val from State	PLACE AND DATE OF DI	oleani		CATION City or	
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	// // // // //	ardens of	Faith Cemetery		Balto.	Md.
	N 12 6 1	7.1.1		Leonard J. Ri	uck Funeral		
\dashv	23. PART I. Enter the disesses, or co	uge fr-		5305 Harford	Rd. Balto.	Md. 21	214
	shock, or heert failure. L. IMMEDIATE CAUSE (Final disesse or condition resulting in death)	ACUI	ch line.	paralal			Approximets Interval Between Onset and Death Murantes
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		CONSEQUENCE OF):				
	d.						
AL	PART II. Other significant conditions	contributing to death bu	t not resulting in th	ne underlying ceuse givan in	Part I. 24s. WAS AN / PERFOR		b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE
Ä					1 🗌 YES 2	₽ NO	OF DEATH?
N: MEC	DID TOBACCO USE CONTR	IBUTE TO CAUSE OF	DEATH YES	□ NO 🗷 UNCERTAII		M NO	
ICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		6. PLACE OF DEATH (C	Check only one)	N []		DF DEATH? 1 YES 2 NO
HYSICIAN: MET	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	2 HOSPITAL: 1 □ Inpetient 2 □ ER/Outpe	6. PLACE OF OEATH (C	HER: Nursing Home 5 Residence	S) Cother (Specify)	COADSIDE	DF DEATH? 1 YES 2 NO
Y PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending	HOSPITAL:	6. PLACE OF OEATH (C	Check only one)	N []	COADSIDE	DF DEATH? 1 YES 2 NO
B	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	HOSPITAL: 1 Inpetient 2 ER/Outpa	6. PLACE OF OEATH (Cottlent 3 DOA 4 DOA 14 DOA 14 DOA 14 DOA 14 DOA 15 D	HER: Nursing Home 5 Residence 28c. INJURY AT WORK? M 1 YES 2 NO	S) Cother (Specify)	20ADS1D6	DF DEATH? 1 YES 2 NO
B	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	20 ER/Outpa 20 ER/Outpa 26a. OATE OF INJURY (Month, Day, Year) 28c. PLACE OF INJURY building, stc. (Specif	6. PLACE OF OEATH (C tlent 3 DOA 4 C 28b. TIME OF INJURY — At home, farm, street y)	HER: Nursing Home 5 Residence 28c. INJURY AT WORK? M 1 YES 2 NO	26d. OESCRIBE HOW IN 26d. OESCRIBE HOW IN 26f. LOCATION (Street e. City or Town, State)	20ADS IDA NUMBER OF RURA THE STATE OF THE	OF DEATH? 1 YES 2 NO Route Number,
BE COMPLETED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	20 ER/Outpa 20 ER/Outpa 26a. OATE OF INJURY (Month, Day, Year) 28c. PLACE OF INJURY building, stc. (Specif	6. PLACE OF OEATH (C tlent 3 DOA 4 C 28b. TIME OF INJURY — At home, farm, street y)	ineck only one) HER: Nursing Home 5	26d. OESCRIBE HOW IN 26d. OESCRIBE HOW IN 26f. LOCATION (Street e. City or Town, State) to the cause(s) end manitime, date end place, end	DADSIDO IJURY OCCUREO INDEP OF RURA INDEP OF RURA Indep of the course	OF DEATH? 1 YES 2 NO Route Number,
E COMPLETED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	20 HOSPITAL: 1 Inpatient 2 ER/Outpa 26a. OATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, stc. (Specification) AM: To the bast of my knowle: On the basis of examination	6. PLACE OF OEATH (C tlent 3 DOA 4 C 28b. TIME OF INJURY — At home, farm, street y) dge, death occurred at end/or investigation, in	the time, date end place, and due my opinion, death occured at the	26d. OESCRIBE HOW IN 26d. OESCRIBE HOW IN 26f. LOCATION (Street e. City or Town, State) to the cause(s) end manitime, date end place, end	DADSIDO IJURY OCCUREO INDEP OF RURA INDEP OF RURA Indep of the course	DF DEATH? 1 YES 2 NO Route Number, (a) end menner as stated.
BE COMPLETED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	2 ER/Outps 2 Se. OATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, stc. (Specific On the basis of examination COMPLETED CAUSE OF DEAT	6. PLACE OF OEATH (C tlent 3 DOA 4 C 28b. TIME OF INJURY — At home, farm, street y) dge, death occurred at end/or investigation, in	HER: Nursing Home 5 Residence 28c. INJURY AT WORK? M 1 YES 2 NO I, factory, office the time, date end piece, and due my opinion, death occured at the D & O	26d. OESCRIBE HOW IN 26d. OESCRIBE HOW IN 26f. LOCATION (Street e. City or Town, State) to the cause(s) end manitime, date end place, end	DADSIDO IJURY OCCUREO INDEP OF RURA INDEP OF RURA Indep of the course	DF DEATH? 1 YES 2 NO Route Number, (a) end menner as stated.

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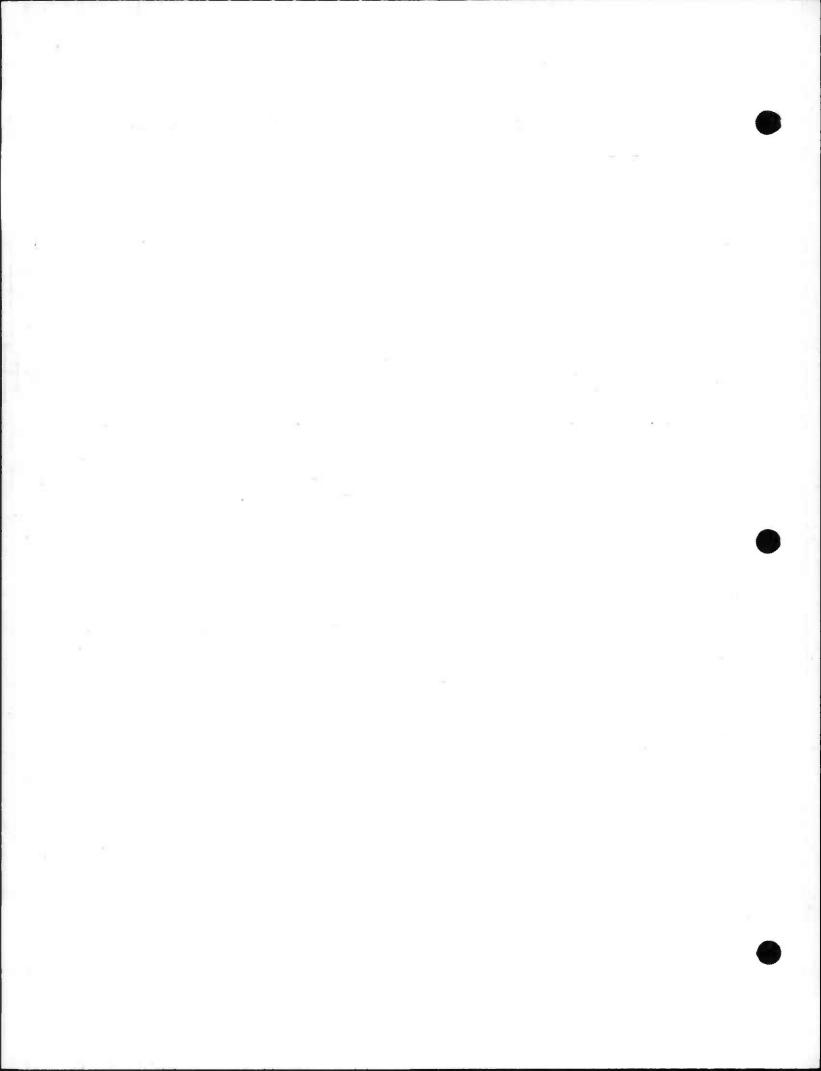


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BALTIMORE, MARYLAND 21215-0020	24 hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should thin the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	re medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the five be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Hem 28 is marked, or Hem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

TE SISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH		YGIENE
ENT'S NAME (First, Middle, Last)		2 DATE OF	DEATH

	FOR STATE REGISTRAR	STATE OF MAP					EALTH DEAT		MENTAL HYGI AEG.			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEAT	Н		3. TIME OF DEATH
	VERA EL	LAINE MCCLURE						July	2, 1	995	6:00 A M	
	THE PERSON NOT SERVICE	5. SEX 6. A	AGE (In yrs. lest bi		IF UNDER		IF UNDER		7. DATE OF BIRTH		8. BIRTI	IPLACE (State or Foreign
3	200 10 1071	1 🗆 M 2 💢 F	61	YRS.	MONTHS	DAYS	HOURS	MIN.	March 3.	1934	We.	st Virginia
~	9a. FACILITY NAME (If not institution, give stre				9b. CITY	TOWN C	R LOCATION	ON OF DE			NTY OF D	
DIRECTOR	2723 Wells Avenu	e					Ec	lgeme	ere	Ba	ultin	nore
EC	10a. STATE 10b. COUNTY		1	loc. CITY,	TOWN C	R LOCAT	ION					10d. INSIDE CITY
PHO	Maryland	Baltimore	,					Edd	gemere		i	LIMITS?
	10e. STREET AND NUMBER					101	. ZIP CODI		1011011	10g. CIT	IZEN OF V	WHAT COUNTRY?
FUNERAL	2723 Wells Avenu	e						21	1219	Un	ited	States
5	11. MARITAL STATUS	12. WAS DECEDENT EV FORCES? 1		D	13.	MAS DEC	ENDENT O	F HISPAN	IIC ORIGIN? (Specify n, Puerto Rican, etc.	Yes or No-	14. RACI	E — American Indien,
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR					2√XNO			,	Spec	"" White
	15. DECEDENT'S EDUCA	ATION	16e. DECE	DENT'S II	SUAL O	CHIPATIC	MI .		165 KIND OF	BUSINESS/INI		writte
E	(Specify only highest grade or Elementary/Secondary (0-12)	ompleted) College (1-4 or 5+)	(Give I	kind of wo	rk done i	during mo	st of working	g	TOU. KIND OF	BUSINESS/INI	JUSTRI	
AP.	7 Years	00.1000 (1-0.101)	Cas	shie	r				Gr	ioceru	Indu	ıstru
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						16. MOTH	IER'S NA	ME (First, Middle, Me	iden Surname)		
BE (Dorsey Lee Jones								ita Lucil			ter
2	19e, INFORMANT'S NAME (Type/Print)								Route Number, City or			
	Mr. Albert C. McC.	lure						Edgi	emere. Mo	arylan	1 2	1219
	20a METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remov	ral from State	20b. PLACE AND cemetery, cremate	DATE OF	DISPOS er plece)	ITION (No	me of	/ + / • ·	DATE 20c	LOCATION —	City or To	wn, State
	4 Donation 5 Other (Specify)	NSEE (var Lo	wn	Ceme	NAMEAN	D ADDRES	15/9:	5 I	Baltu	nore,	MD
	2A11									ne of 1	Dunde	alk, Inc.
	D/(M				1 5	1922	Wisc	AUG	o. Dunde	TPb M	2	1222
	23. PART I. Enter the diseases, or co shock, or heart fellure. Li	st only one ceuse of	used the death on each line.	i. Do no	t enter	the mo	de of dyl	ng, auch	h aa cerdiac or re	espiratory an	reat,	Approximate Interval Batween
	IMMEDIATE CAUSE (Final disease or condition							0 0	_		Onset and Death	
	resulting in death)				- hon Small cell lun				I kung	lanc	2/	18 mouth
_		(•	,		
5	Sequentially list conditions, if any, iseding to immediate	OUE TO (OR	AS A CONSEQUE	NCE OF)	:							
CA	CAUSE (Disease or Injury											
	that initieted events resulting in deeth) LAST	DUE TO (OR	AS A CONSEQUE	NCE OF)								
CERTIFICATION	d.					_						
	PART II. Other algnificent conditions	contributing to dear	th but not reau	ulting in	the un	derlying	ceuse g	iven in I		AN AUTOPSY	24b	WERE AUTOPSY FINDINGS
200	_ Ovanan Co	arcinom	a						1	S 2 NO		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME									, ,			1 YES 2 NO
ä	DID TOBACCO USE CONTRI	BUTE TO CAUSI					UNC	ERTAIN	1 💢			
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE O		(Check		-/		/			
IYS	1 VES 2 NO	1 Inpetient 2 ER/		DOA 4	□ Nun	ing Hom		sidence	6 Other (Specify)			
	1 Natural 5 Pending	(Month, Day, Ye		6b. TIME INJU		28c. INJI WO	JRY AT RK? ES 2	1 110	28d. DESCRIBE HO	W INJURY OC	CURED	
BY	Accident Investigation 3 Suicide B Could not be	28e. PLACE OF INJ	IURY — At home	farm, str	net tect			NO	28t. LOCATION (Str	net and Mumbu	or Drumt S	Sauta Mirashara
	4 Homicide 8 Could not be determined	building, etc. ((Specify)	,	,	.,,			City or Town, S	fete)	Ur riuren r	oute number,
COMPLETED	290. CERTIFIER 1 CERTIFYING PHYSICI	AN: To the best of my k	nowledge death	on our me d	et the st	no dete	and alsos					
MA I	(Check only one) 2 MEDICAL EXAMINER:) and menner as stated
	29b. SIGNATURE AND TITLE OF CERTIFIER						29c. LICE					(Month, Day, Year)
BE	marilda t	H. Sa	A A						250	29d. 0A1	1210	(Month, Day, 1687)
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF	F OEATH (ITEM 27	7) (Type, P	rint)		,		- 30		[2]	7.5
	MATILDA H.	So. 1	447	YOR	KR	D.	Lu	THE	PEUILLE,	mp 2	LING	13
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S	SIGNATURE	*		-					- 0	
	JUI 1 0 1995 Juli	Mudeenles	fall									
											-	DHMH, 16 Rev 1/89



1995

9c. COUNTY OF DEATN

Howard

U.S.A.

3. TIME OF DEATH

11:53

10d. INSIDE CITY LIMITS?

1 TES 2 W NO

8. BIRTHPLACE (State or Foreign Country)

Maryland

10g. CITIZEN OF WHAT COUNTRY?

Specify:

White

14. RACE - American Indien, Black, White, etc.

Ам

2. DATE OF DEATH

6

July

4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. leet birthday) 7. DATE OF BIRTN IF UNDER 1 YEAR | IF UNDER 24 HRS. 1 M 2 F YRS. 212-58-2744 9-18-52 permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not inetitution, give etreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 6200 Ashton Park Ct. Columbia RESIDENCE OF DECEDENT 10b. COUNTY 19c, CITY, TOWN OR LOCATION Maryland Howard Columbia FUNERAL 10f. ZIP CODE requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. 6200 Ashton Park Ct. 21044 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-MARYLAND 21215-0020 1 Never Married 2 St Married If yes, specify Cuben, Mexican, Puerto Rican, etc.) Specify: BY 3 Widowed 4 Divorced ETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EQUICATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 4 yrs Consultant Ford Motor Company once. 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Surneme) notified at Francis A, Martin BE Reese 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Ann P. Martin 6200 Ashton Park Ct. Columbia, Md.21044 must be 20e. METHOD OF DISPOSITION

1 Display Burlet 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND OATE OF DISPOSITION (Name of DATE cemetery, crematory or other plece)
Crestlawn Memorial medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Towson Funeral Home, Inc. York Rd. Towson, Md. 21204 Ruck 1050 completely filled in by the rial, cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart fellure. List only one ceuse on each line to burial, cremation, or IMMEDIATE CAUSE (Final Malignant Melanoma, metastatic the disease or condition traumatic event, resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 **OUE TO (OR AS A CONSEQUENCE OF** CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or Injury Hygiene prior other 1 DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 6 been signed by the atter PHYSICIAN: MEDICAL PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? shows any 1 - YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN Dept. 23 OR ATTENDING PHYSICIAN: The law has 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) this certificate h HOSPITAL: OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) marked, or the 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 TYES BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suictde 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) DIRECTOR: A item 28 Is 6 Could not be 4 Homicide COMPLET 29e. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) end manner as estated. (Check only one) TO THE HOSPITAL
TO THE FUNERAL I
De filed within 72 h
IMPORTANT: If it 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 45025 +1 am 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF CEATN (ITEM 27) (Type, Print)

Davideor Rodal

1. DECEDENT'S NAME (First, Middle, Lest)

Robert

0 1995

31. DATE FILED (Month, Day, Year)

DENNIS RYAN MARTIN

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

m 22 S. Green St. University Hospital
32. REGISTRAR'S SIGNATURE

20c. LOCATION — City or Town, State 7-10 Marriottsville, Md Approximate Interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DE DEATH? 1 TYES 2 T NO 29d. OATE SIGNED (Month, 95 DHMH-16 Rev 1/89

1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

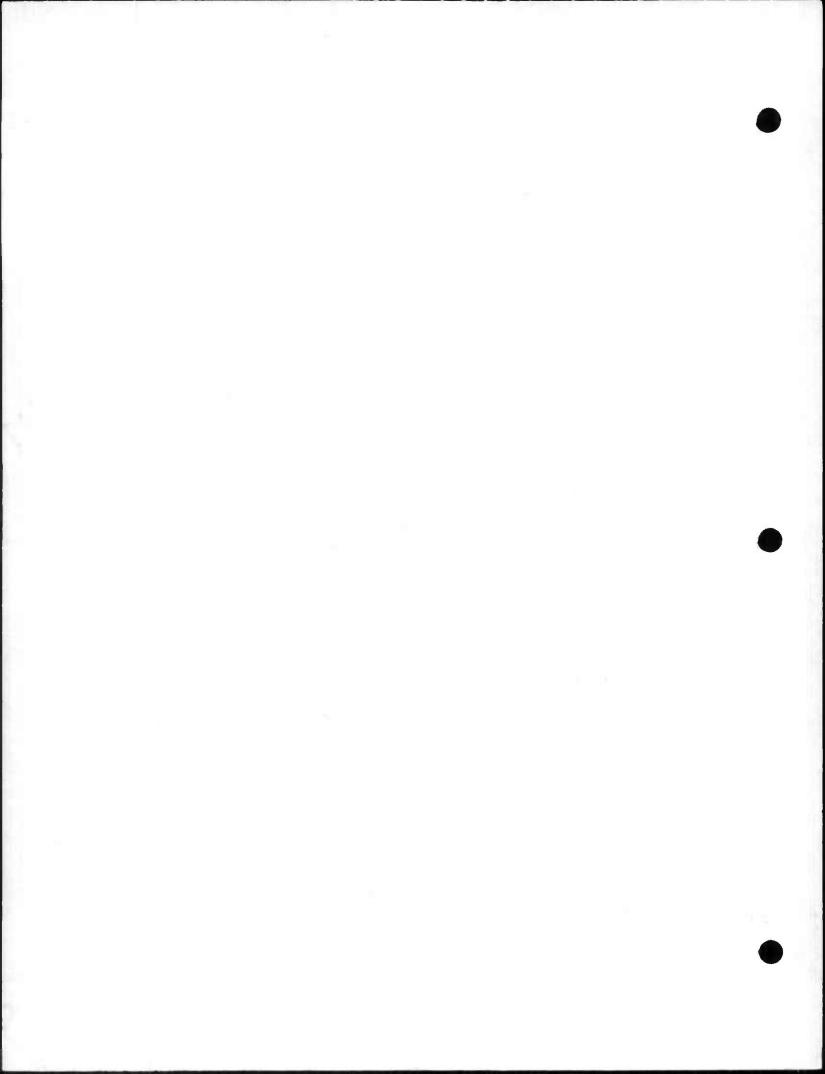
_	nsit permit. Pages			
ter death. Page 6 may be retained by the hospital or attending physician.	the funeral director, page 5 should be detached for use as the burial-transit per	wal.	a examiner must be notified at once	
IO THE MUSPITAL OR ALTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at ence	THE PERSON NAMED IN COLUMN TO SERVICE OF THE PERSON NAMED IN CO.

REGISTRAR			CERTIF	10111		DEM	111		REG. N	O.		
1. DECEDENT'S NAME (First, Middle, Last) ADELINE	MART	TRE						MONT	OF DEATH	DAY	YEAR	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER	5. SEX		down felial at a					_	ne 30	, 199.		8:03 P.
142-32-5335	1 M 2 XF	79	. last birthday) YRS.	IF UNDER	DAYS	HOURS	MIN.	7. DATE (Mont	of Birth th, Day, Year) Ch 14	1916	6. BIRTI	IPLACE (State or Foreign) Ealy
9a. FACILITY NAME (If not institution, give	The second		(0.27)	9h. CITY	TOWN C	B LOCATI	ON OF DE		CII 14		INTY OF D	
Stella Maris					Tow		011 01 00				alti	
RESIDENCE OF DECEDENT							_					
10a. STATE 10b. COUNT				Y, TOWN								10d. INSIDE CITY LIMITS?
Florida Br	oward		Н	allar			-					1 X YES 2 NO
	Shores B	lvd.				3300°					.S.A	WHAT COUNTRY?
11. MARITAL STATUS	12. WAS DECEDEN		ARMED	13.	WAS DEC	ENDENT (OF HISPAN	HC OBIGH	N? (Specify Y			E — American Indian.
1 Never Married 2 Married	FORCES? 1 IF YES, GIVE W	YES 2	⊉ NO		If yes, sp	cify Cube	ın, Mexica	n, Puerto	Rican, etc.)	88 OF NO.	Blac	k, White, stc.
3 TWidowed 4 Divorced						200 110	орасну				Spec	White
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12 yrs.	<i>_</i>		Restau	ant (Jwile.						oyed	
Giuseppe	Barone						HER'S NA		Middle, Maide arone	n Sumame)		
19a. INFORMANT'S NAME (Type/Print)	Darone		19h MAII INC	ADDRES	S /Street -				ber, City or To	Cu	in Control	
Dr. Joseph Marti	re	TI.	732						ber, City or 16 moniu			093
20s. METHOD OF DISPOSITION		20b PL A	CEANDDATE	OE DISPOS	NAME OF THE	me of		DAT		OCATION -		
1 Buriel 2 Cremation 3 Ren 4 Donation 5 Montal Specify		Dula	crematory or c	ther place)	v Ma	us.	. 7	/3/9			,	aryland
21. SIGNATURE OF FUNERAL SERVICE E	CENSEE	7	//				SS OF FA				<u> </u>	050 York
· /= //	-///											
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23. PART I. Enter the diseases or	complications that		death Do								nc.T	owson,Md.
23. PART I. Enter the diseases or shock, or heart fallure.	complications that	odused the	death, Do i								nc.T	Approximate interval Betw
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a fear death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, gage 5 should be detached for use as the burial-transit narmit Panes 1 2 servuir	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - STATE REGISTRAR	STATE OF MARYLAND		ENT OF HEALTH AND		GIENE 3. NO.		
	1. DECEDENT'S NAME (First, Middle, Last) GOLDIE	L. NELS			2. DATE OF DEMONTH	DAY	YEAR 3. TH	ME OF DEATH
		5. SEX 1 M 2 F 5 9	YRS. MONT		7. DATE OF BIR (Morth, Day,) APRIL	27 1936	MARYL	(State or Foreign
DIRECTOR	NORTH ARUNDE			GLEN BURA		AUN	TY OF DEATH	UNDEL
L DIRE	10a. STATE 10b. COUNTY MARYLAND ANNE A 10a. STREET AND NUMBER	RUNDEL		VERNA PARK	(A		10	NSIDE CITY LIMITS? YES 2 💢 NO
FUNERAL	232 BALTIMORE ANN	APOLIS BOULEVA		101. ZIP CODE 21146	1110 000000	USA	EN OF WHAT C	
BY	1 Never Married 2 Married 3 Widowed 4 X Divorced	FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	NO	If yes, specify Cuben, Mexic 1 YES 2 NO Specific	can, Puerto Rican, e	tc.)	14. RACE — Arr Black, White Specify: WH	ITE
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT use retir	one during most of working	115055110	OF BUSINESS/INDU	ISTRY	
	17. FATHER'S NAME (First, Middle, Last)		MEMAKER	18. MOTNER'S N	IAME (First, Middle, A	USEHOLD Welden Surname)		
TO BE	RICHARD N. ROWIF 194. INFORMANT'S NAME (Type/Print) I.J. FORDHAM			RESS (Street and Number or Rura TIMORE ANNAP)				21146 PARK, MD
D	20s. METHOD OF DISPOSITION 1 XBurlal 2 Cremation 3 Remov	rel from State 20b. PLAC cometery,	CE AND DATE OF DIS	POSITION (Name of	DATE 2	GLEN BUI	ity or Town, Str	nte
	21. SIGNATURE OF FUNERAL SERVIPLY CO	ings dr.		22. NAME AND ADDRESS OF F STALLINGS FUL	VERAL HON	ME P.A.		
	23. PART I. Enter the diseases, or co	mplications that caused he lat only the cause on each li	death. Do not er	3111 Mountain	ch as cardiac or	respiratory arre	st.	Approximate
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	Mystan	SEQUENCE OF)	Sugart	in			Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONS	MOUENCE OF):	helt.	Coch	}.		
	DART II Other cignificant conduces							
PHYSICIAN: MEDICAL	PART II. Other algorificant condition	rellilus;	t resulting in the	underlying cause given is	PI	MS AN AUTOPSY ERFORMED3 (ES 2 MO	AMAILA COMPL OF DE	AUTOPSY FINDINGS ABLE PRIOR TO LETION OF CAUSE ATH? /ES 2 NO
N.	DID TOBACCO USE CONTRI				IN 🗆			
SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	28, PL HOSPITAL: 1 Inpatient 2 ER/Outpatient		IER:				
H.	27. MANNER OF DEATN	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF	Nursing Nome 5 Residence 28c. INJURY AT WORK?		NOW INJURY OCCU	JRED	
BY	1 Natural 5 Pending 2 Accident Investigation		•	1 YES 2 NO				
	3 Suicide 8 Could not be 4 Homicide determined	26s. PLACE OF INJURY — At building, etc. (Specify)	home, farm, street,	factory, office	28t. LOCATION (S City or Town,	Street and Number or State)	r Rurel Route Nu	imber,
COMPLET		AN: To the best of my knowledge, On the basis of examination and/o						sanner as stated.
TO BE	SIGNATURE AND TITLE OF CERTIFIER	Sarni	1	D36	256	294. DAYE S	SIGNED (MUSIK)	195.
	30 NAME AND ADDRESS OF PERSON WHIS	wood los	Surt	106 Aller	1 kur	wie t	100	2/06/
	JULI 0 1995" Juli	R. REGISTRAR BIGHATURE						



9c. COUNTY OF DEATH

Baltimore

10g, CITIZEN OF WHAT COUNTRY?

United States

Specify.

14. RACE — American Indian, Black, White, etc.

3. TIME OF DEATH

B. BIRTHPLACE (State or Foreign

Pennsylvania

10d. INSIDE CITY

1 TES 2 X NO

White

21222

Queet and Death

Approximate interval Batween

24b. WERE AUTOPSY FINDINGS

AVAILABLE PRIOR TO COMPLETION OF CAUSE

1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

m D

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2. DATE OF DEATH

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	1
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FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Gerald Wayne Prettyman, Sr. July 5, 1995 6. AGE (In yrs. lest birthday) F UNDER 1 YEAR F UNDER 24 HRS. 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year)

June 15, 1940 DAYS HOURS 220-36-7199 1 X M 2 - F permit. Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 913 Wise Avenue Dundalk RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maruland Baltimore Dundalk FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 913 Wise Ave. director, page 5 should be detached for use as the burial-transit 21222 Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, atc.) **ORE, MARYLAND 21215-0020** 1 Never Married 2 Merried FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 2 XNO BΥ 1 YES ZX YNO Specify 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use refired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) 8 Years Bodu & Fender Mechanic 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surner notified at Unknown BE Kathrun Marie Prettuman 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Maru Lindsau Prettuman Wise Ave. Dundalk. Maruland 9 20a, METHOD OF DISPOSITION
1 2 Juriei 2 Cremation 3 Removal from State
4 Donation 5 State (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must cemetery, crematory or other pla Sacred. Heart. Of Jesus 7/8/95 Jesus 7/8/95 Baltimore, Maruland 21. SHINATURE OF STATE BERVICE LICENSEE examiner filled in by the funeral Duda-Ruck Funeral Home of Dundalk, Inc. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. sedo after medical 6 **IMMEDIATE CAUSE (Final** the 24 arteriosclero disease or condition resulting in death) acuk Monic cardivas delas and completely other traumatic event, DUE TO (OR AS A CONSEQUENCE OF): the attending physician and con Mental Hygiene prior to burial, charge CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 shows any injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY signed by the 1 TES 2 NO U epan den tego õ has be Dept. PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h Item EXAMINER? HOSPITAL: OTHER:
4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 6 the state 27. MANNER OF DEATH 28a. DATE OF INJURY with t 28b. TIME OF INJURY 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED is marked, Natural 5 Pending 1 YES 2 NO DIRECTOR; After the hours after death v BY 2 Accident investigation 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Flural Route Number, City or Town, State) 6 Could not be determined COMPLETED 28 4 🗌 Homicide Tem! 29e. CERTIFIER

(Chark only

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner as stated. FUNERAL F within 72 h = MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) and menner se stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 296. SIGNATURE AND TITLE OF CERTIFIER 290 LICENSE NUMBER

Donovan, M.D

Julia of hubban hardell

2112 DUNDALK

AVE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) OY) ONOVAN

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

BE

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Cuossan ?

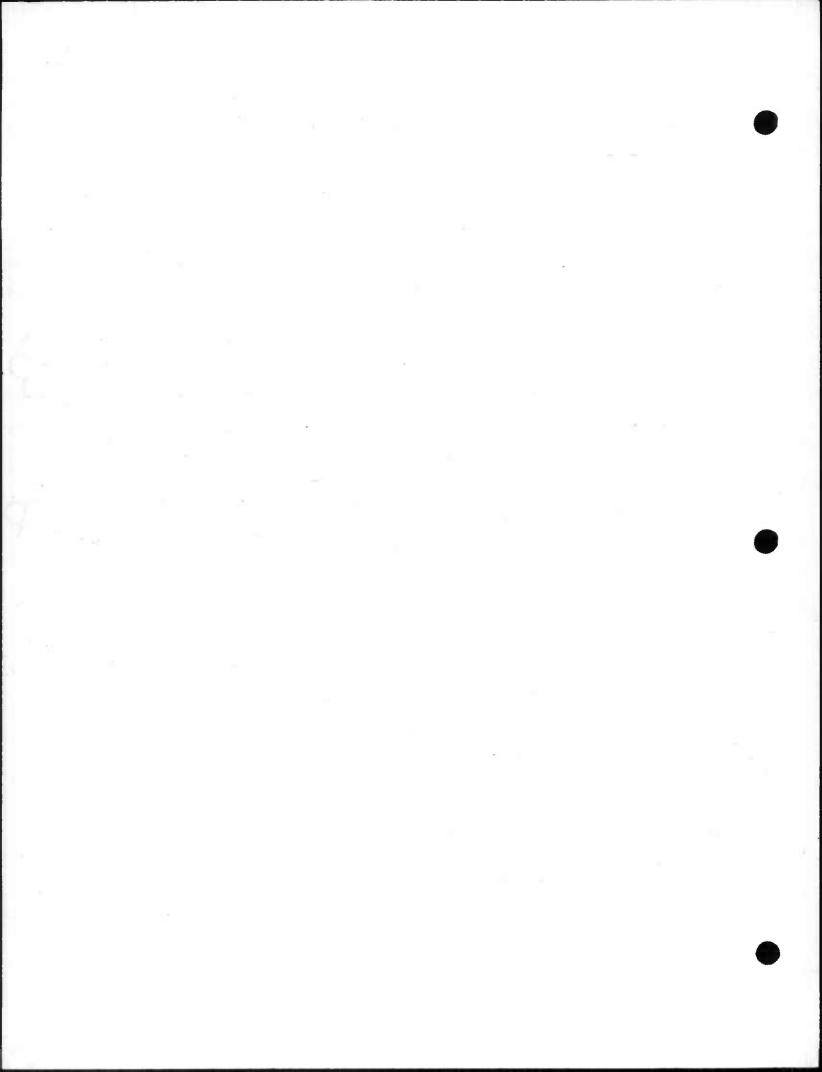
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0 1995

31. DATE FILED (Month, Day, Year)

21222

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al or attending physician. for use as the buriat-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

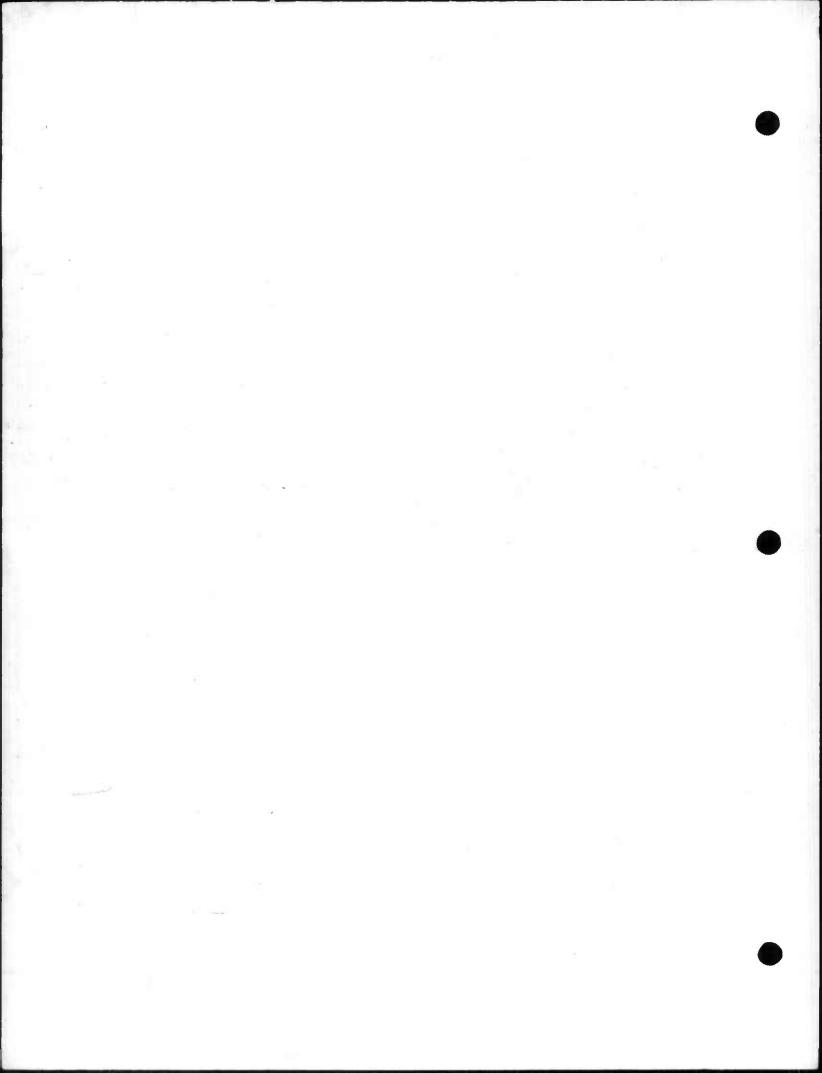
	1 - FOR STATE REGISTRAR	STATE OF MARY		RTMENT OF I		MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH D	AY YE	3. TIME OF DEAT	н
		WRIGHT	RIGHT PARKS, JR.			Jul 5 198		5:20 pm	М
	4. SOCIAL SECURITY NUMBER		69 YRS.	F UNDER I YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. B	HRTHPLACE (State or Follountry)	reign
	216-20-7144		69 YRS.			Dec. 29, 1	.925	Md.	
œ	9a. FACILITY NAME (If not institution, give at Saint Joseph Medica				OR LOCATION OF DE		9c. COUNTY (
5	RESIDENCE OF DECEDENT	11 Ceriter		1048	on, Marylar	10	Baltim	TOPE	
DIRECTOR	10a. STATE 10b. COUNTY		10c. CI	TY, TOWN OR LOCA				10d. INSIDE CITY LIMITS?	
		ltimore			erville			1 🗆 YES 2 📑	NO
RAI	100. STREET AND NUMBER 1626 Pickett Rd.			10	21093			OF WHAT COUNTRY?	
FUNERAL	11. MARITAL STATUS	12 WAS DECEDENT FUED	MILLO ADMED					.S.A.	
	1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 2 YES IF YES, GIVE WAR OR	3 2 NO	If yea, sp	ecify Cuban, Mexicar		1 3	RACE — American India Black, White, etc.	in,
BY	3 Widowed 4 Divorced	WW-I]		1 L YES	2 NO Specify.			Specify: White	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	ATION completed)	16a. DECEDENT'S	B USUAL OCCUPATION	ON ast of working	16b. KIND OF BUS	SINESS/INDUSTI		
Ä	Elementary/Secondary (0-12)	College (1-4 or 5+)	IIIa. Do NOT	ise retired.)					
MP	17. FATHER'S NAME (First, Middle, Last)	5+	Insura	nce Ager		Insura			
	Lawson W.	F	Parks		Edna	NE (First, Middle, Maiden		nueler	
BE	19a. INFORMANT'S NAME (Type/Print)	-	0.21.0	G ADDRESS (Street)		oute Number, City or Town			
5	Mrs. Beverly Parks	5				erville, M			
	20a. METHOD OF DISPOSITION 1 Burlal 2 □ Cremation 3 □ Remo	20	D. PLACE AND DATE	OF DISPOSITION (Na	rme of	DATE 20c. LO	CATION — City of	or Town, State	
	4 Donation 5 Other (Specify)	Du	inetery, cremetory or ilaney Va	illey Men	. Gdns.	7/8/95 Ti	.monium	, Md.	
	21. SIGNAPORE OF FOREBAL SERVICE LIC	CO 3			TOWSON	Funeral Ho	me Inc	7	
	LA motor	- Chi				. Towson,			
	23. PART I. Enter the diseases, or c ahock, or heart fellure. I.	omplications that couse	ed the daeth. Do	not entar the mo	de of dying, such	as cardiec or respi	ratory arrest,	Approxime	
	IMMEDIATE CAUSE (Final							Onset and	
	disease or condition resulting in death)	CARDIAC AR						IMMED.	
			A CONSEQUENCE O	The second second	DELLOTE	NOCATO!			
S	Sequentially list conditions, "	ACUTE, RECE	A CONSEQUENCE O		PIONAL	MITOCARDIA	ıL.	DAY#/	
S	if any, leading to immediate cause. Enter UNDERLYING		NFARCTIO					WEEKS	
Ē	CAUSE (Disease or Injury that initiated events		A CONSEGUENCE O					11.000	
CERTIFICATION	reaulting in deeth) LAST	ATHEROSCLI	EROTIC CO	DRONARY	ARTERY DE	BEASE		YEARS	
	PART II. Other aignificent conditions	contributing to death	but not resulting	In the underlyin	cause given in F			24b. WERE AUTOPSY FIR	NDINGS
MEDICAL	HISTORY OF LYMPH	IOMA AND RE	CENT CHE	MOTHERA	PY	PERFOR		AVAILABLE PRIOR T	
MEC	HISTORY OF RIGHT	CEREBROVAS	CULAR AC	CIDENT		_ /~		OF DEATH?	10
	DID TOBACCO USE CONTR	IBUTE TO CAUSE O	OF DEATH Y	ES NO C	UNCERTAIN				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF DEA	TH (Check only one) OTHER:					
IXSI	1 TYES X NO	1 Inpetient 2 ER/Out		4 - Nursing Hom	e 5 🗆 Realdence (Other (Specify)			
	27. MANNER OF DEATH Netural 5 Pending	(Month, Day, Year)	28b. TII	JURY WO	RK?	26d. DESCRIBE HOW I	NJURY OCCURE	D	
B	2 Accident Investigation 3 Suicide Could not be	28e. PLACE OF INJUR	Y At home, farm.		rES 2 NO	28f. LOCATION (Street a	nd Number or D	Prote North	
9	4 Homicide 8 Could not be	building, etc. (Spe	ecify)			City or Town, State)	no Namour or riu	ret rioute Number,	
COMPLET	29a. CERTIFIER CERTIFYING PHYSIC	IAN: To the beat of my know	riedne, death occur	and at the time, date	and place, and due t	a the annuals) and man			
N N		3: On the beals of examination						ee(a) and manner ea sta	nted.
	296. SIGNATURE AND MILE OF CERTIFIER	11	1)11	0	29c. LICENSE NUM			NED (Month, Day, Year)	
) BE	often (AR MI) Pathr	locat	D34543			7, 1995	
٩	30. NAME AND ADDRESS OF PERSON WHO								
	STEVEN R. AXE, M.D.			DSEPH MI	ED. CTR., T	OWSON, ME). 21204		
	JUL 1 0 1995 Julia daudler Real !!								

20803 95

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68764 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

_		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
	REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

CARDELL PARKER 1. S. DEC. 1. S. DOOL, SECURITY HUMBER 1. S. DOOL, SECU		REGISTRAR		CERT	TIFICATE	OF DEATH	REG.	NO.	
A SECULT MARKET OF CHARGE AT ALL PARKETS AND PROCESS TO THE STANDARD PROCESS TO THE STANDARD AND PROCESS TO THE ST	1)				2. DATE OF DEAT		3. TIME OF DEATH
TO THE STATE OF THE PROPERTY OF THE STATE OF	- 8	CARDELL		PARI	KER		MAY 26	, 1995	18:05
NANCOSTIA RIVER Name		4. SOCIAL SECURITY NUMBER			MONTHS D		(Month, Day, Ye	er)	BIRTHPLACE (State or Fore Country)
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321.2 Peronne Avenue 321.2 Peronne Avenue 322.2 Peronne Avenue 323.2 Peronne Avenue 324.2 Peronne Avenue 325.2 Married 2	EG		TY	100	CITY, TOWN OR	OCATION			104 INSIDE CITY
MASTING STATUS Deep Company De									1 YES 2 N
Total Prince Company	VERA	3212 Peronne Ave	nue			10f. ZIP CODE		10g. CITIZE	EN OF WHAT COUNTRY?
To PATT II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 246. NAS AN AUTOPEY PERFORMED TO MEDICAL EXAMINER. 100 PETAL 100 PE	B	1 Never Married 2 Married	FORCES? 1 1	ES 2 NO	If y	is, specify Cuban, Mexico	an, Puerto Rican, etc		
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The importance of the property of the proper		Elementary/Secondary (0-12)	College (1-4 or 5+)						
199. MALING ADDRESS (Street and Number or Rural Roum Number. City or Now., Stein, Zip Code) 190. MALING ADDRESS (Street and Number or Rural Roum Number. City or Now., Stein, Zip Code) 200. METHOD OF DEPOSITION 1 Burfel 2 Commettion 3 September of Promission 5 Control Roumble (Street) 11. Statte 2 connection; connection of Commetting State 1 Connection; connectio		17. FATHER'S NAME (First, Middle, Last)						iden Sumame)	
200. PLACE AND DATE OF DISPOSITION 1 Burlet 2 Committon 3 Removal from State 2 Connection, committee	0	19a. INFORMANT'S NAME (Type/Print)		19b. MA	ILING ADDRESS (S			Town, State, Zip C	Code)
22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore St., Baltimore, MD 2120 23. PART I. Enter the diseased, or complications that caused the death. Do not enter the mode of dying, auch as cerdiac or respiratory arrest, independent and provided in the provided interval and provided interva		1 Buriel 2 Cremation 3 Res				ON (Name of	DATE 200	LOCATION — CI	ty or Town, State
23. PART I. Enter the dibeased, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, abock, or heart failure. List only one cause on each line. MINISTRICT CAUSE (Final disease or condition resulting in death) DRONNING				Jada Di	22 NAI	AF AND ADDRESS OF EA	CHITY Choho	A = a = a = =	D 1
Interval B Chapter (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):		Inwest /	alle	wade, Di		W. Baltimo	ore St.,	Baltimo	у воага re, MD 21201
PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 PYES 2 NO 24b. WERE AUTOPSY FAMILABLE PRIOR 25c. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 PYES 2 NO 25c. WAS CASE REFERRED TO MEDICAL EXAMINER OF DEATH 1 Inpution 1 EVER 26c. PLACE OF DEATH (Check only one) 27c. MANNER OF DEATH 27c. DEATH 27c. LICATION (Street and Number or Flural Route Number) 27c. LICATION (Street and Number or Flural Route Number) 27c. LICATION (Street and Number or Flural Route Number) 27c. LICATION (Street and Number or Flural Route Number) 27c. LICATION (Street and Number or Flural Route Number) 27c. LICATION (Street and Number or Flural Route Number) 27c. LICATION (Street and Number or Flural Route Number) 27c. LICATION (Street and Number or Flural Route Number) 27c. LICATION (Street and Number or Flural Route Number) 27c. LICATION (Street and Number or Flural Route Number) 27c. LICATION (Street and Death and Death and Death and Death at the time, date and place, and due to the cause(e) and manner are stated. 27c. LICENSE NUMBER		IMMEDIATE CAUSE (Final disease or condition	DROWNING		CE OF):				Onset and
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FOUND ON 5/26/95 3:40 PM 1 YES 2 X NO UNKNOWN 280. PLACE OF INJURY — At home, farm, street, fectory, office determined 290. CERTIFIER (Check only one) 290. SIGNATURE AND TYTLE OF DESTRUCE: 290. SIGNATURE AND TYTLE OF DESTRUCE: 290. SIGNATURE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 290. STREET BALTIMORE, MARYLAND 21201 31. DATE FILED (Month, Day, Year) 40.0 5	HYS								
3 Suicide 6 Could not be determined 286. PLACE OF INJURY — At home, farm, street, fectory, office City or fown, State/BLADE NSBURG MARINA— NORTHEAST END 8LADENSBURG MARINA— NORTHEAST END 8LADENSBURG MARY 1 CERTIFFING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date end place, and due to the cause(e) end menner ee stated. 296. SIGNATURE AND TITLE OF CERTIFIER 296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Veer) 296. SIGNATURE AND TITLE OF CERTIFIER 296. DATE SIGNED (Month, Day, Veer) 297. LICENSE NUMBER 298. DATE SIGNED (Month, Day, Veer) 298. SIGNATURE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 298. SIGNATURE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 298. SIGNATURE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 298. SIGNATURE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 298. SIGNATURE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 298. SIGNATURE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 298. SIGNATURE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 298. SIGNATURE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 298. SIGNATURE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 298. SIGNATURE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 299. SIGNATURE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 299. SIGNATURE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 299. SIGNATURE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 299. SIGNATURE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 299. SIGNATURE AND ADDRESS OF TOWN AND ADDRESS OF TOWN AND ADDRESS OF TOWN AND ADDRESS OF TOWN AN			(Month, Day, Ye	er) FOL		WORK?		ow indon't occo	neo
296. SIGNATURE AND TYPE OF CERTIFIER 296. LICENSE NUMBER OCME 296. LICENSE NUMBER OCME MAY 27, 1995 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo., Print) THE PLAN STREET BALTIMORE, MARYLAND 21201 31. DATE FILED (Month, Day, Yan) 40.0 G. 32. REGISTRAR'S SIGNATURED	0	3 Suicide 8 Could not be determined 1 Homicide 1 Homicide 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify)					BURG MARINA-		
29c. LICENSE NUMBER OCME 29d. DATE SIGNED (Month, Day, West) OCME MAY 27, 1995 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) The print of the pri	OMPLE	(Check only					to the cause(e) end	menner ee stated	
OCME MAY 27,1995 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) OWIG RESONATION STREET BALTIMORE, MARYLAND 21201 31. DATE FILED (Month, Day, Year) 40.05 32. REGISTRAR'S SKONATURED	ш								
Owid R Fower 111 PENN STREET BALTIMORE, MARYLAND 21201	0		Gran			OCM	E	► MA	Y 27,1995
31, DATE FILED (Month, Day, Year) 400 5 32, REGISTRAR'S SIGNATURES		David R	Fowler	111		TREET BAL	TIMORE,	MARYLA	ND 21201
		31. DATE FILED (Month, Day, Year) 1995	32. REGISTRAR'S S					<u> </u>	



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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2s hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1.2 3 should
be filed within 72 hours after death with the State Dept, of Health and Memtal Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIRECTOR

FUNERAL

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CERTIFICATION

MEDICAL

PHYSICIAN:

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C. WALLACE

. MDo GIL

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Jul. y Flora B. Ryner P .M 10:15 06 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign April 27,1931 DAYS HOURS 349-22-4264 1 M 2 XF 64 YRS. Illinois 9s. FACILITY NAME (If not institution, give street and number) 96, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Deaton Medical Center Baltimore N/A RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland N/A Baltimore 1 X YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 524 N. Charles Street #1302 21201 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-if yee, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married Specify: Black 1 TYES 2 NO Specify: 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade College (1-4 or 5+) Elementary/Secondary (0-12) 3 Nurse Health Care 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Rockel Williamson Nellie Cook 19e, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Williamson (Brother) 1101 St. Paul Street Baltimore, Maryland 21202 20a. METHOD OF DISPOSITION
1 ☐ Buriel 2 (X Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata DATE 4 Donation 5 Other (Specify) Metro Crematory July 11, 1995 Catonsville, Maryland 21. SIGNATURE OF EARLERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes 1630 Edmondson Avenue Catonsville Maryland course 23. PART I. Enty the diseases, or complications that eaused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, smock, or haert fallure. List only one ceuse on each lina. Approximate Interval Batween IMMEDIATE CAUSE (Finel Onset and Death disease or condition resulting in death) CARCINOMA 425 Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST PART ii. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 TYES 2 NO I inpatient 2 - ER/Outpatient 3 - DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident 5 Pending 1 YES 2 NO Investigation 28e. PLACE OF INJURY — At home, ferm, atreet, fectory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined. 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. 2 MEDICAL EXAMINER: On the of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) and menner ee stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 995 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

S. CHARLET

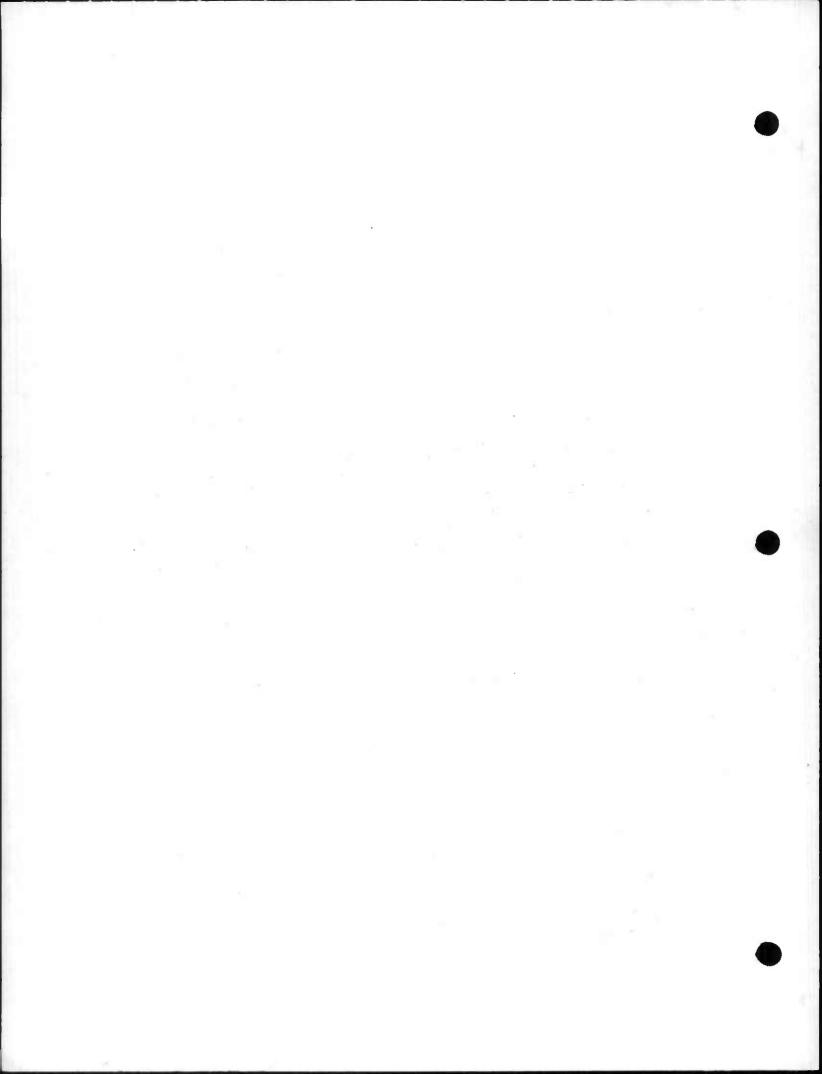
BALLIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Derf of Health and Mental Mulline prior to burial cremation or removal	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, F.O. BOX 66760	TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the itself and within 72 hours after death with the State Dent of Health and Mental Hydisine prior to build cremation or remova-	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last)													
3							MONTH DAY YE			YEAR	3. TIME OF DEATH			
OMP	4. SOCIAL SECURITY NUMBER				last birthday)	st birthday) F UNDER 1 V		FAR IF IMOER 24 MDS						O PU III
	705–12–7859		1 🕅 M 2 🗌 F	81		MONTHS	DAYS	HOURS	MIN.	Apr.	23,	1914	Count	Ohio
	9e. FACILITY NAME (If not institution, give street and number) 10230 Shaker Drive									_				
	RESIDENCE OF DECEDENT					Columbia						Lu		
S I	10e. STATE 10b. COUNTY				10c. CIT	10c. CITY, TOWN OR LOCATION 1nd INSIDE						10d. INSIDE CITY		
	MD	Howa	ard		Co	lumb	ia							LIMITS? 1 YES 2 NO
ERAL	6525 Overheart Lane				101. ZIP CODE 21045				10g. CITIZEN OF WH			VHAT COUNTRY?		
5	manager . Comment . Re.												14. RACE	E — American Indian,
8	1 Never Married 2 Married FORCES? 1 YES 2 XIP IF YES, GIVE WAR OR DATES				XINO									
	15. OECEDENT'S EDUCATION (Specify only highest grade completed)			DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working)				v2	16b, KINO OF BUSINESS/INOUSTRY					
9	Elementary/Secondary (0-12) College (1-4 or 5+)			·)	Ille. Do NOT u		001 07 17 01101		D 0 0 D-11					
\$	12 None Cox											a		
	Thomas Ro										e, Maiden	Surname)		
	19a. INFORMANT'S NAME (7)	ype/Print)		T	19b. MAILING	ADDRES	S (Street	and Number	or Rural F	Route Number, C	ity or Town	. State. Zic	Specify: White Approximet	
۲	Thomas Worp)										
	20a, METHOD OF DISPOSITI 1 ☐ Burlal 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other	ION on 3 M Remo (Specify)	val from State	20b. PLAC Cemetery Hamd	CEANDDATE	ther plece)	1	L.	July	DATE				
- 1	21. SIGNATURE OF FUNEYA	L SERVICE LICE	EARTE (
	Kuss	uca	We &	Le			eroy 555	& Ru Twin	Kno.	lls Rd	Ke E Co	uner lumb	ia. I	MD 21045
	23. PART I. Enter the di shock, or he IMMEDIATE CAUSE (Fin disease or condition resulting in death)	eert fellure. L	RODGES S. ST. S. BEZ R. AGE (IP yrs. Nat birmody) FLOCOR 1 TAXA FLOCO											
TION	Sequentielly liet conditions, b. HY PERLIPIDEMIA DUE TO (OR AS A CONSEQUENCE OF): 271.5													
HILLCALION	cause. Enter UNDERLY! CAUSE (Disease or Inju that initiated events reaulting in death) LAS	SEQUENCE O	UENCE OF):											
- 11	DADT II Cohor chesillocat and little and and and little and and little and and little and and little and and little and and and and and and and and and and													
₹	Pres	IA. I S	Mua	CAD O	1 /	in the ur	nderiyin	CT/A	given in	Part I. 24a			24b.	AMAILABLE PRIOR TO
		1003	1.190	77700	15-	101	HIL			10	YES 2	X(NO	Separation of the state of the	
Σ	DID TORACCO II	SE CONITO	IDLITE TO CA	UCE OF DE	ATLL VI	· C T	NO F	7 11116	EDTAIL					1 TYES 2 NO
AN			IBUTE TO CA						EKIAIN	10				
BY PHYSICIAN: MEDICAL	EXAMINER? HOSPITAL: OTHER													
	1 YES 2 10								sidence					
	1 detural 5	Pending Investigation					WC	ORK?) NO	26d. DESCRIE	IE HOW IN	JURY OC	CURED	
- 4	3 Sulcide 6	Could not be determined	28e. PLACE O building,	F INJURY — At atc. (Specify)	home, farm,	street, fact	WORK? 1 YES 2 NO ctory, office 281. LOCATION (Street and Number or Rural Route Number.							
4	29a. CERTIFIER CONTINUE PHYSICIAN, T. M.													
	CONTROL OF THE STATE OF THE STA													
	Maurice affec ML					D 381								11885
		A. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)												
-	31. DATE FILED (Month. Date)	TO JO STOCK TO ROLL TO THE COLORS OF THE STATE OF THE STA												
	JUL 1 0 19	95 Ju	U WINDOWS	4-ACTIVITIES										



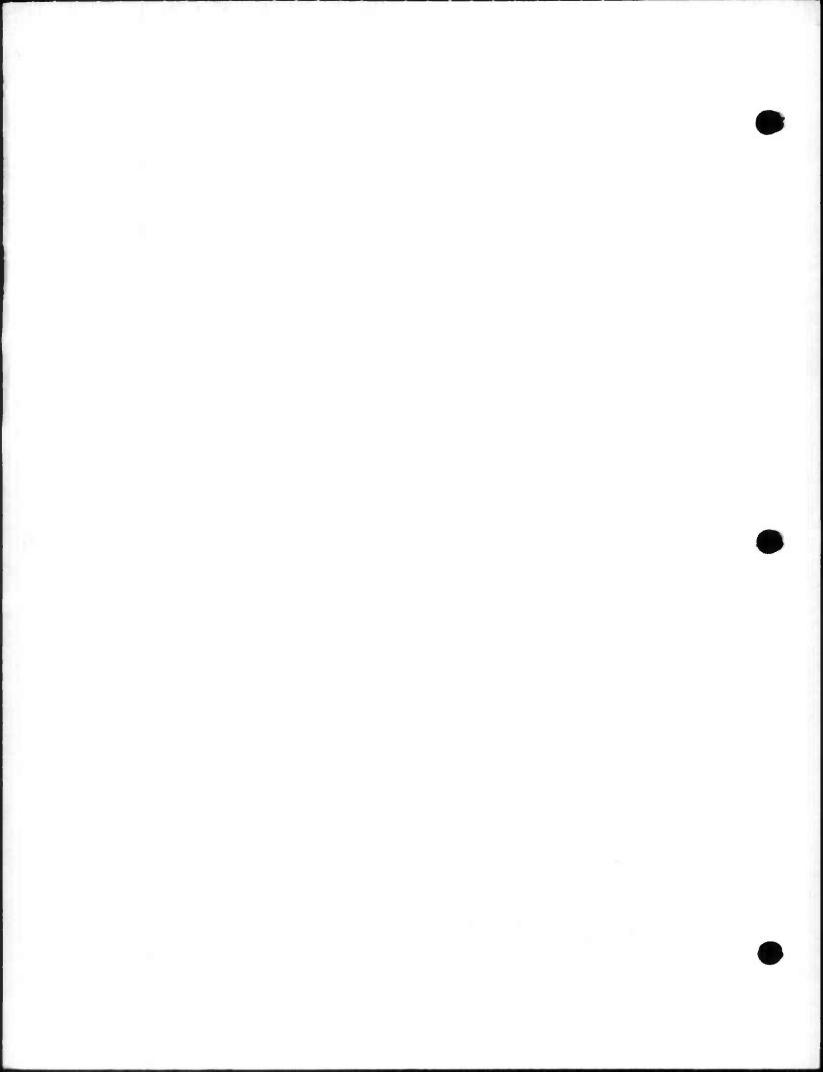
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an about a feet of the feet of the feet of the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENI
REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

	REGISTRAR		CERTIFIC	ATE OF	DEATH	REG. N	0.			
	1. DECEDENT'S NAME (First, Middle, Last)	Reeves				2. DATE OF DEATH		3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 5	SEX 8. AGE (In yrs.		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)		
стоя	Se FACILITY NAME (If not institution, give stree HICE Manor	t and number)	2.5	CITY, TOWN O	R LOCATION OF DE	March 12,	9c. COUNTY	V OF DEATH		
DIRE	10a. STATE 10b. COUNTY	A	10c. CITY, TO	OA H	on O			10d. INSIDE CITY LIMITS? 1 YES 2 \(\square\) NO		
ERAL	2095 Roder	10g. CITIZEI	N OF WHAT COUNTRY?							
BY FUN	11, MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	ARMED XINO		olfy Cuben, Mexice	NIC ORIGIN? (Specify Yon, Puerto Ricen, atc.)	se or No 14	Black, White, etc. Specify: Black		
PLETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor Elementery/Secondary (0-12)	mpleted)	DECEDENT'S USU (Give kind of work life. Do NOT use re	done during mos	N t of working		Dumes	TRY		
COMPL	17. FATHER'S NAME (First, Middle, Last)	mason		0161	16. MOTHER'S NA	ME (First, Middle Maide	n Surname)			
TO BE	192 INFORMANT'S NAME (Type/Print) Deborah M.		196. MAILING ADI	Wedge	d Number or Rural I	Route Number, City or To		1 21229		
	20a, METHOD OF DISPOSITION 1	I from State 20b. PLAC	E AND DATE OF DI	ISPOSITION (Nan	ne of	DATE 20c. L		y or Town, Ştate		
	21. SIGNATOREOF FUNERAL SERVICE LICEN				ADDRESS OF FA	7 7 3	Ave	,		
	23. PART L. Enter the decises, or come shock, or heart feliure. Lis immediate Cause (Fine) disease or condition resulting in dasth)	pplications that coused the tonly one cause on sech if	leal	4	s of dying, such		piratory arrest	t, Approximata interval Batwee Onset and Deat		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONS								
CERTI	resulting in death) LAST									
: MEDICAL CI	PART II. Other significent conditions of	ontributing to deeth but no	t resulting in th	ne underlying	csuse given in	Part I. 24a. WAS A PERFO	RMED?	24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH?		
AN: N	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25, WAS CASE REFERRED TO MEDICAL 26, PLACE OF DEATH (Check only one)									
PHYSICIAN:	EXAMINER? 1 VES 2 NO 1	OSPITAL: Inpatient 2 ER/Outpatient	01	HER:	5 - Residence	6 ☐ Other (Specify)				
D BY PH	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	WOR		28d. DESCRIBE HOW	INJURY OCCUR	BED		
I W I	3 Suicide 8 Could not be determined	281. LOCATION (Street City or Town, State	LOCATION (Street and Number or Rural Route Number, City or Town, State)							
COMPLET	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) and manner as stated.									
TO BE COMP	29c. LICENSE NUMBER 29d. DATE SIGNED (Month,									
F	Richard L Diamond M.D. 3730 Falls Rd. Baltimore Md. 21211									
	31. DATE FILED (Month, Day 995 July	White the state of		130.00						



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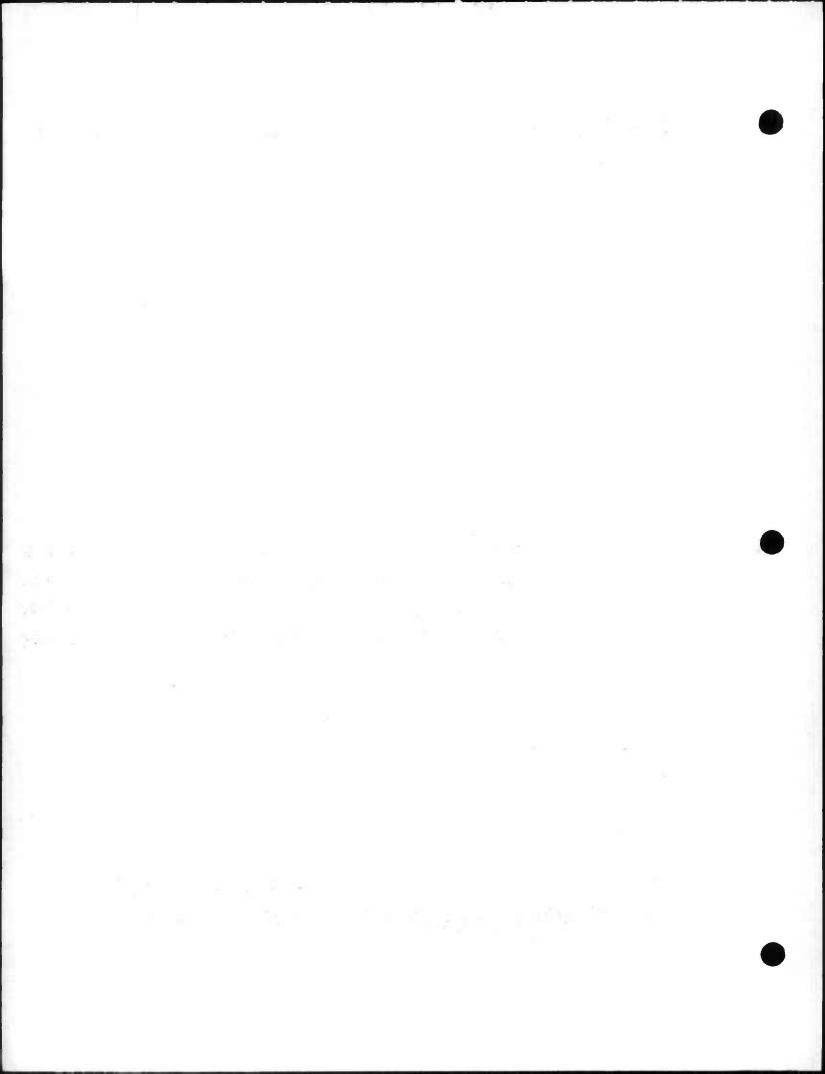
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	to this control with the State begin of Health and Mertal Hygiene prior to build, cremation, or removal.	IMPORTANT: if Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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95 20807 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ESTER M. SCHMIDT JUZY 12:14 OCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 71 DAYS Country 1 🔯 M 2 🗆 F 215-18-3415 Sept. 8 Maryland 9a. FACILITY NAME (if not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR University Hospital Baltimore N/A RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Catonsville 1 YES 2X NO FUNERAL 10e, STREET AND NUMBER 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2012 Old Frederick Road 21228 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: BY Specify: 3 Widowed 4 Divorced WWII White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 12 Warehouse Supervisor Construction 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) George Schmidt Cora Boehlein BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Hazel Schmidt (Spouse) 2012 Old Frederick Road Catonsville, Maryland 21228 20b. PLACE AND DATE OF DISPOSITION (Name of Line) 12, 1995 20a. METHOD OF DISPOSITION
1 № Burlel 2 □ Cremation 3 □ Removal from State 20c. LOCATION - City or Town, State emetery, cremetory or other place)
Oudon Park Mausoleum 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland SIGNATURE OF FUNDRAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes Lacerege 1630 Edmondson Avenue Catonsville Maryland 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, **Approximate** shock, or hasrt failure. List only one cause on each line Interval Betwe IMMEDIATE CAUSE (Final Onset and Death disesse or condition resulting in death) ONE MONTH CERTIFICATION ONE WEEK Sequentially list conditions, DUE TO (OF if any, leading to immediate cause. Enter UNDERLYING ONE WEEK CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST ONE WEEK PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO IN UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL:
1 Prinpetient 2 ER/Outpetient 3 DOA **EXAMINER?** OTHER:
4 □ Nursing Home 5 □ Residence 8 □ Other (Specify) 1 YES 2 AO 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Naturel 1 YES 2 NO ΒY 2 Accident Investigation 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined 9 4 Homicide COMPLET 29e. CERTIFIER (Chack only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. STATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Manth, Day, Year) BE 195 2

OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

22 S GREENE ST



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR		CEI	RTIFIC	ATE OF	DEATH		REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last Marie S	OISTMAN					2. DATE OF MONTH JULY	DEATH	199	YEAR 3	TIME OF DEATN 2:40 Am
	4. SOCIAL SECURITY NUMBER										
	214447102 9e. FACILITY NAME (If not institution, give	1 □ M 2 ∰ F	82	YRS. MO	NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, D SEPT	lay, Year)	912	Country) KAN	
TOR	FRANKLIN SOUARE	-		96		SVILLE	EATN	Baltimore County			
REC	10a. STATE 10b. COUN	1 1/2		10c. CITY, TO	OWN OR LOCA	TION	1			10	Dd. INSIDE CITY LIMITS?
LD	MD BALTI	IMORE			BALTI						☐ YES 2 NO
FUNERAL DIRECTOR	43 CLIFFWOOD RO		21206			21206	US.				AT COUNTRY?
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 YES, GIVE WAR O				ecify Cuban, Mexic	exican, Puerto Rican, etc.) Bia				American Indien, white, atc.
田	15. DECEDENT'S ED (Specify only highest grad	UCATION le completed)	18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working				16b. Kr	ND OF BUS	BINESS/INDU		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	HOMEMAKER				(OMN HO	ME		
	17. FATHER'S NAME (First, Middle, Last) MICHAEL HAU	F'TMAN				18. MOTHER'S NA			Sumame)		
TO BE	19a. INFORMANT'S NAME (Type/Print)		19b. A	MAILING ADI	DRESS (Street	and Number or Rural			n, State, Zip i	Code)	
	JOHN CROCKEN 200. METHOD OF DISPOSITION		43 CL.TFFWOOD ROAD B.						MD 21		
	12 Buriel 2 Cremation 3 Rer 4 Donation 6 Other (Specify)		cemetery, crema		placa)	ame of	7/11	DATE 20c. LOCATION — City or Town, State 7/11 BALTIMORE, MD			
	21. SIGNATURE OF SUNERAL SERVICE L	ICENTEE)	TALSAY	LAIM	22. NAME A	ND ADDRESS OF FA	CILITY)
	16940	2			121	CH/ROSEDA	TTI T C	PATT	V) ME) 2:	1237
	23. PART i. Enter the diseasea, or allock, or heart feilure.	complications that cau List only one cause or	sed the deeth	h. Do not e	enter the mo	de of dying, suc	h aa cardled	or reapi	ratory arre	st,	Approximate interval Between
	iMMEDIATE CAUSE (Final disease or condition	Canabaarra	1	A = - 1 3	1						Onset and Death
İ	resulting in death)		S A CONSEQUE	ACCIO	ient						24 hrs.
NO NO	Sequentially list conditions,										15 years
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury										
Ħ	that initiated events resulting in death) LAST	DUE TO (OR A	S A CONSEQUE	ENCE OF):	•						
Ö	DART II ON a state of	d									
EDICAL	PART ii. Other algnificant condition	ns contributing to deeti	n but not ree	ulting in th	ne underlyln	g ceuse given in		PERFOR	MED?	AV	ERE AUTOPSY FINDINGS AILABLE PRIOR TO DMPLETION OF CAUSE
ME							_ '	YES 2	MO.	1	DEATH?
	DID TOBACCO USE CONT	RIBUTE TO CAUSE				UNCERTAI	N 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:		ОТ	HER:		162 1			-	
PHY	27. MANNER OF DEATN	28e. DATE OF INJUF (Month, Day, Yee	Y 2	66. TIME OF	28c. INJ	e 5 Residence URY AT	26d. DESCRI		JURY OCCL	JRED	
ВУ	1 Natural 5 Pending 2 Accident Investigation				M 1 🗆	res 2 No					
ETE	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJU building, atc. (S	inty — At home, ipecify)	, ferm, street	i, factory, offic		281. LOCATIO City or To	ON (Street e own, State)	nd Number o	r Rural Rout	e Number,
COMPLETED		SICIAN: To the best of my kn									nd manner ee stated.
BE C	29b. SIGNATURE AND TITLE OF CERTIFIE					29c VICENSE NUI					onth, Day Year)
2	(/ fo	Mon	0	N		47	27	'	> 7	7-8-	-81
	30. NAME AND ADDRESS OF PERSON WE Anthony Joseph MI					D = 1	-				
I	31. DATE FILED (Month, 0005)	9000 Fran	HATTHE S	quare	DETAG	Baltin	nore.	<u>laryl</u>	and	2123	7
16	ARE I A MAN										-

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760.

	REGISTRAR		CERTIFI	CALE	OF DEATH		REG. NO) <u>. </u>			
!	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR VALUE 4. 1995										
	4. SOCIAL SECURITY NUMBER		In yrs. last birthday)	IF UNDER 1 YE	EAR IF UNDER 24 HRS.	7. DATE	OF BIRTH	7 /7	BIRTHPI	DG30 LACE (State or Foreign	
	219-40-6185	1 🗆 M 2 💢 F	55 YRS.	MONTHS DA	AYS HOURS MIN.	(Monti	1, Day, Year)	140	Country)	14.1	
,	9e. FACILITY NAME (If not institution, give s	freet and number)		9b. CITY, TO	WN OR LOCATION OF D		23,11	9c. COUNT	Y OF DE	TH .	
ECION	NORTH ARUNDER	HOSPITAL	_	11/10	n BURN	. 6		Aures	to	UNDEI	
TRESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION											
			200	TOWN OR L	Edgem					Od. INSIDE CITY LIMITS?	
	Maryland 100. STREET AND NUMBER	Baltimore				T 40 - 0/7/7/		TES 2 X NO			
Š	7817 Denton Aven	1110			10f. ZIP CODE 21		1				
LONEHAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS	17 (Specify Ve			tates			
	1)(Never Married 2 Married	FORCES? 1 YES		13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxicen, Puerto Rican, etc.) 1 YES 2 (S) NO Specify:					Black, Specify:	- American Indian, White, etc.	
	3 Widowed 4 Divorced				,	,			оресну.	White	
	15. DECEDENT'S EDUC (Specify only highest grade		16a. DECEDENT'S U	ork done durin	PATION ng most of working	16b	KIND OF BU	SINESS/INDU	STRY		
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	7.65							
L	12 Years 17. FATHER'S NAME (First, Middle, Last)		Machi	rist				ıstria	l		
		le .			18. MOTHER'S NA						
	ROY F. Pyles . S. 19a. INFORMANT'S NAME (Type/Print)	L	19h MAII INC 4	Innesse (%	Oberte:				anda'i		
2	James Feathers				ight Court					06	
	20a. METHOD OF DISPOSITION 1 & Burlel 2 Cremetion 3 Remo		PLACE AND DATE OF	-		DAT	_	CATION - CI			
	1 Burial 2 Cremation 3 Reme 4 Donation 5 Other (Specify)	oval from State cen	etery, cremetory or other	er placed on	netery 7/8	195				ontown,	
ı	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	1	22 NAM	AF AND ADDRESS OF FA	CILITY	1100	190000	LINUS	· ·	
- 1	- Land	SHO	/	700	aa-kuck fu	rerai	. Home	06 Vu	ındal	k, Inc.	
7	23. PART I. Enter the diseases, or s	mplications that caused	tha death. Do no	ot enter the	22 Wise Au	h an care	liac or man	iratory erre	yean	d 2122	
- 1	shock, or beart tellure.	List only one cause on a	ich line.							Interval Bet Onset and I	
		METASTAT	ic lu	ER	DISENSE					A Va	
	disease or condition										
	Sequentially list conditions, BREAST CARCINDA										
	If any, leading to immediata	DUE TO (OR AS A	CONSEQUENCE OF):								
	CAUSE (Disease or injury	DHE 70 (OD AC A	CONSEQUENCE OF								
CEMINICATION	that initiated eventa resulting in death) LAST	DOE TO (ON AS A	CONSECUENCE OF):							İ	
3		d						-			
4	PART ii. Other significent condition	a contributing to death be	ut not resulting in	the under	lying ceuse given in	Part i.	24a. WAS AN			ERE AUTOPSY FINE	
PUICAL							1 TES 2		0	OMPLETION OF CA	
Ξ										TYES 2 NO	
	DID TOBACCO USE CONTE					NK					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	OTHER:	one)						
3	1 YES 2 NO 27. MANNER OF DEATH	Inpatient 2 ER/Outp	etient 3 DOA 4	I ☐ Nursing	Home 5 - Residence						
- 10	1 Natural 5 Pending	(Month, Day, Year)	28b. TIME INJUI	RY	WORK?	28d. DES	CRIBE HOW I	NJURY OCCU	RED		
	2 Accident Investigation 3 Suicide a Could as be	28e. PLACE OF INJURY	- At home, farm, etc		YES 2 NO	285 LDC	ATION /Street	and Number of	Burni Dev	da Mumba-	
3	4 Homicide 8 Could not be	building, etc. (Spec	ify)	.,,	- Car. 10		or Town, State)		THE PROPERTY OF	ituitioi,	
	29e. CERTIFIER	CIAN: To the heat of any knowl	adaa daath	ed the st		1175					
JMPL		CIAN: To the best of my knowlers: On the basis of examination								nd manner as elek	
3	29b. SIGNATURE AND TITLE OF CERTIFIER	77 ~		,y spinin			and prece, en			0.00	
4	Marc South	JA (1-1)	M.D		7 454	NBER Q (/				forth, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHI	D COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type 5	Print)	1 5 434	70		1	144	4,41	
		o Fed DINE			UNDER HO	IR FE	DI C	1 G-1 FA	VRIE	WHE MOO	
-	31. DATE FILED (MONTH POR (YELF)	324 REGISTRAR'S SIGNA		- 44./	1002 100	יי עות	-	4.0	301	117,02	
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completely filled in by the funeral director, page 5 should be detached for use as the ial, cremation, or removal.

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CERTIFICATION

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Pages 1, 2, 3 should

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8	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 29	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fi	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	8	H	DO	ten
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH STINE BREAKER 0118 Lorna JUNE 1995 27. 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign 7. DATE OF BIRTH (Month, Day, Year)
May 18, HOURS 178-26-8390 1 M 2 TF 63 YRS PEnnsylvania 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH WICOMICO DIRECTOR PENINSULA REGIONAL MEDICAL CENTER SALTSBURY RESIDENCE OF DECEDENT 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? New York Niagra Falls 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 623 9th STreet 14301 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2X NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—if yee, specify Cuban, Maxican, Puerto Rican, etc.)
 The Yes of the Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married Specify: white BY 3 🔀 Widowed 4 🗌 Divorced 15. DECEDENT'S EDUCATION ETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest (Give kind of work done life. Do NOT use retired.) condary (0-12) College (1-4 or 5+) COMPL 12 teacher's aide education 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname, Lloyd Homer Russell Minnie Viole Goss BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Kenneth W. Stonebraker 623 9th STreet, Niagara Falls, New York 14301 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State 1 Burial 2 Cremation 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ROMALD Wade, Dir. 22. NAME AND ADDRESS OF FACILITY State Anatomy BOARd 655 W. Baltimore ST., Balto., MD 21201 naen 23. PART I. Entar the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heart failure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition DUE TO (OR AS A COMPROUENCE OF): resulting in death) Myo Cardial Lypuly acute HRS Sequentially list conditions, DUE TO (OR AS A CONSEQUE If any, leading to immediate SCUD . Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other significant conditions contributing to death but not reaulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 70 OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO INCERTAIN IN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 YES 2 NO 1 Impetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Realdence 6 Other (Specify) 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 26c, INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE NOW INJURY OCCURED 1 Matural M 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Nomicide datarmined

Lunded M. 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 29c. LICENSE NUMBER 10688

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2 __ MEDICAL EXAMINER: On the beats of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

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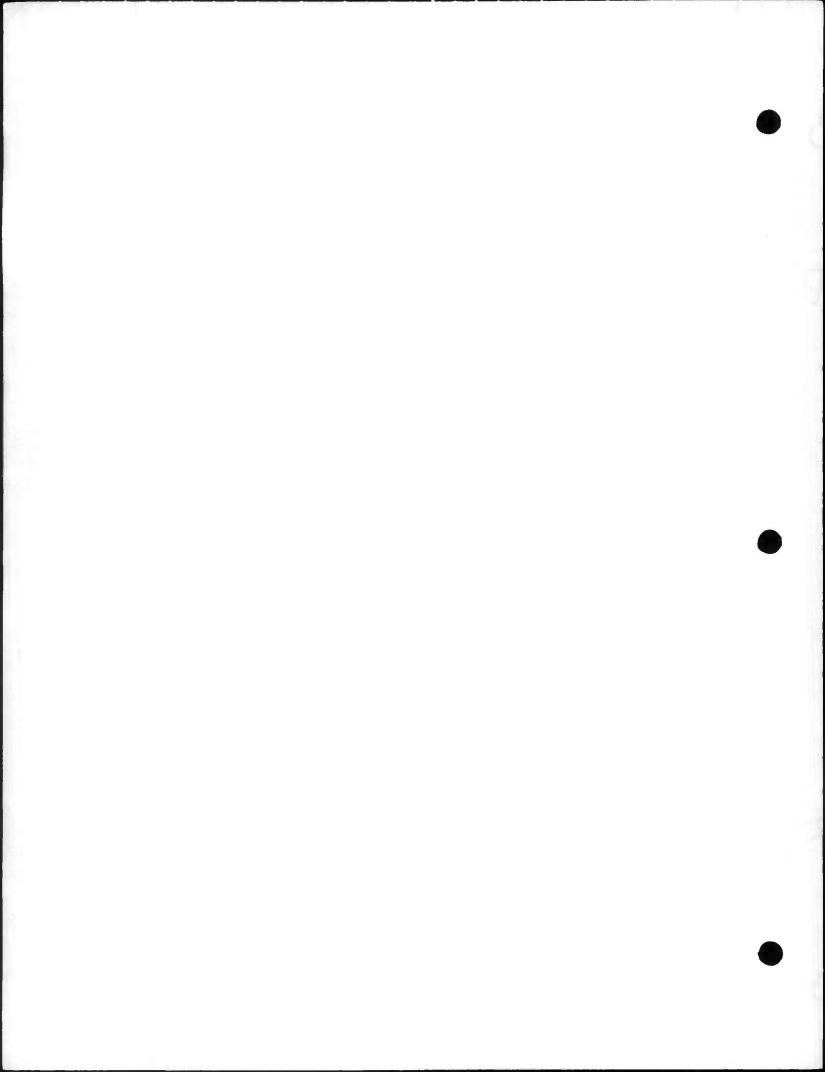
29d. DATE SIGNED (Month, Day, Year) 6/21

milled QUINCY 31. DATE FILED (Month, Day, Year)

JUL 1 0 1995 32. REGISTRAR'S SIGNATURE

296. SIGNATURE AND TITLE OF PERTIFIER

29a. CERTIFIER
(Chack only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and manner as stated.



DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR

	HEGIST FAR			EUIIL	IONI	2 01	DEA	111	REG. NO			
- 6	1. DECEDENT'S NAME (First, Middle,	Last)							2. DATE OF DEATH		3.	TIME OF DEATH
- 1	MARIA BARI	SARA TROV								6 1	1995	2.00 % M
	4. SOCIAL SECURITY NUMBER		5. SEX 8. AGE (In yrs. les			1 YEAR	IF UNDER		7. DATE OF BIRTH	0 1		2:00 A. M
	1000 1000 1000 1000 1000	Contract of			MONTHS	DAYS	HOURS	MIN.	Advert Con Man		Country)	ACE (State or Foreign
1 1	218-28-0232	1 □ M 2/√F	88	YRS.		MAY 16, 1907 Pennsy					nsylvania	
	Se. FACILITY NAME (If not institution,		9b. CITY	, TOWN	OR LOCATI	ON OF DE	ATH	Sc. COL	JNTY OF DEAT	гн		
<u>۳</u>	18013 Highf	bend blai			7.	shto	n			Mo	ntacma	3077
DIRECTOR	RESIDENCE OF DECEDEN		A	SIILO	11	_		MO	ntgome	ELY		
S I	10e. STATE 10b. CC			10c, CIT	Y, TOWN	OR LOCAL	TION	_			T #	Id, INSIDE CITY
E I	Maryland B	altimore										LIMITS?
		altimore			Tows					1 TYES 2 ANO		
₹	10e. STREET AND NUMBER			101, ZIP CODE 10g. CITIZEN (FIZEN OF WHA	T COUNTRY?		
FUNERAL	412 Alabam	a Road				21204 U.S.A					.S.A.	
5	11. MARITAL STATUS	ARMED	13.	WAS DEC	ENDENT O	OF HISPAN	IC ORIGIN? (Specify Yes	or No-	14 BACE -	American Indian		
	1 Never Married 2 Married	XNO	If yes, specify Cuban, Mexican, Puerto Rican, etc.)						American Indian, fhite, etc.			
BY	3 🔀 Widowed 4 🗌 Divorced	ir res, dive v	WAR OR DATES			1 🗌 YES	24 NO	Specify			Specify:	
	15. DECEDENT'S	EDITORI	100.0	DECEDENT'S		00110471						nite
2	(Specify only highest			(Give kind of the Do NOT us	work done	during ma	ost of working	ng	16b. KIND OF BU	SINESS/IN	DUSTRY	
7	Elementary/Secondary (0-12)	College (1-4 or 5	+)		,		_					
COMPLETED		2 yrs.	Se	ec./T	reası	ure	Tro	y's	Inc. Farm	Equ	ip.&In	ternationa
Ö	17. FATHER'S NAME (First, Middle, Las	1)					18. MOT	HER'S NAI	ME (First, Middle, Maiden	Sumame)		Trucks
BE (William I	. Streett					Mar	y The	eresa Myer			
	19e. INFORMANT'S NAME (Type/Print)			9b. MAILING	ADDRESS	S (Street a		_	Route Number, City or Tow		(a Cada)	
임	Wm. Robert Troy		1	P.O.					on, Maryla			
								arkt				
	20s. METHOD OF DISPOSITION 1 M Burlei 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION /Name of DATE DATE 20c. LOCATION — City or Town, State											
	4 Donation 5 Other (Specify) Dianey Valley Mem. Gds. 7/8/95 Timonium, Maryland											
- 1	21. SIGNATURE OF PUNERAL SERVICE	E LICENSEN /			22.	NAME AF	ND ADDRE	SS OF FAC	CILITY			
i i	1	7/	1	1	R	uck	TOW	son	Funeral	Hon	ne, In	nc.
	car	$\alpha \cdot / \alpha$	nagge		1	050	Yor	k R	d. Towso	n, N	<u>1d. 2</u>	1204
	23. PART I. Enter the diseases,	or complications the ure. List only one cal	t church the c	death. Do r	not enter	the mo	de of dy	ing, suct	as cerdiac or respi	iratory er	reet,	Approximete
	IMMEDIATE CAUSE (Final	1 7	///	10.								Interval Between Onset and Death
	disease Dr condition											
	resulting in death)	n. DUE TO	(OR AS A CONS									
_ {		1/12.15		EGGENGE G	, ,.							i
EDICAL CERTIFICATION	Sequentielly list conditions,	b	(OR AS A CONS	EOHENCE OF	m.							
F	If any, leading to immediate cause. Enter UNDERLYING	552.10	(OIT NO A CORO	EOUENCE O	r).							<u>'</u>
<u>일</u>	CAUSE (Disease or injury	c										
Ë	that initiated events resulting in deeth) LAST	DUE TO	(OR AS A CONS	EOUENCE O	F):							
E	roading in dodiny Exci	d										
O	PART ii Other significant cond	Minne contribution to	death but a	141								
Ž I	PART II. Other aignificent cond	mona contributing to	death but not	reeuiting	in the un	ideriyin	g ceuse g	given in i	Part i. 24a. WAS AN PERFOR		6 401 116	RE AUTOPSY FINDINGS ARLABLE PRIOR TO
8 1									1 _ YES 2	NO	CO	MPLETION OF CAUSE DEATH?
ME						/						YES 2 10
	DID TOBACCO USE CO	NTRIBUTE TO CA	USE OF DE	ATH YE	5 नि	NO F	LINC	ERTAIN			1 ''	co
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICA			CE OF DEAT			, 5140	FIX IVAII				
S	EXAMINERY 1 VES 2 NO	HOSPITAL:			OTHER	R:						-
≥		1 Inpatient 2		-	· ·			eldence	6 Other (Specify)			1.0
E	27. MANNER OF DEATH	28e. DATE OF (Month, D	INJURY ay, Year)	28b. TIM INJ	E OF URY	28c, INJ WO	URY AT		28d. DESCRIBE HOW I	NJURY OC	CURED	
B≼	1 Natural 5 Pending 2 Accident Investigat	lon			М		YES 2	NO				
	3 Suicide 6 Could no	28e. PLACE O	F INJURY - AI	ome, farm, s	street, fact	ory, office	•		28f. LOCATION (Street a	and Numbe	r or Rural Rout	Number
E	4 Homicide determine		atc. (Specify)					1	City or Town, State)			574 50%
COMPLETED	29e. CERTIFIER											
를	(Check only	HYSICIAN: To the best of										
6	2 MEDICAL EXA	MINER: On the beele of e	camination and/or	r Investigatio	n, In my o	pinion, d	eath occur	ed at the t	time, date end place, en	d due to ti	he ceuse(e) en	d manner ee stated,
	29b. SIGNATURE AND TITLE OF CERT	IFIER _ /	2/				29c LICE	NSF NUM	SER	20d DAT	E SIGNED (14	noth Clay Vand
29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month).									min, Day, rear)			
2	30 NAME AND ADDRESS OF DESCRIPTION	I WHO COMES THE CO	2/				11	207	10		1/6/	75
	30. NAME AND ADDRESS OF PERSON										c	
	Dr. Robert	Stolz 14	47 Yor	ck Rd	L. L	uth	ervi	.lle	, Md. Su	ite	605	
	31. DATE FILED (Month Day Sear)	22. REGISTRA	R'S SIGNATURE									
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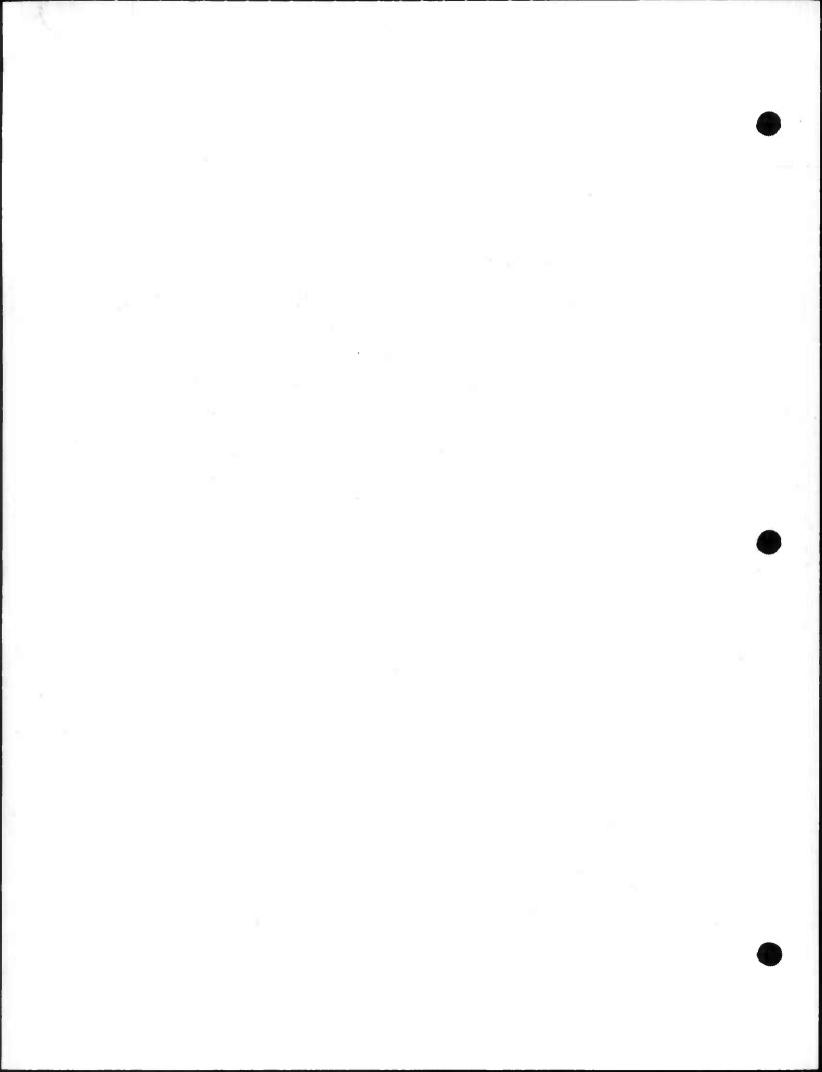
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF I		MEI	NTAL HYGIEN	E				
	1. DECEDENT'S NAME (First, Middle, Last)					DATE OF DEATH		YEAR	3. TIME OF DE	ATH		
	ANNA CARO		(In yrs. lest birthday)					1995	TEAR	6:00	a M	
	4. SOCIAL SECURITY NUMBER	DATE OF BIRTH (Month, Day, Year)				Foreign						
	220-46-1522 Sa. FACILITY NAME (If not institution, give s	1□M2⊠F 88	YRS.				eb. 8,190			many		
Œ			- 1		OR LOCATION OF	DEATH		9c. COUN				
CTO	Manor Care-Ruxton			Towson		_		Baltimore				
DIRECTOR	10a. STATE 10b. COUNT			, TOWN OR LOCA	TION			10d. INSIDE CITY			ry	
	Maryland Balt	imore	Bald							1 TES 20		
FUNERAL	14258 Baldwin	Mill Rd		10	21013			U.S		EN OF WHAT COUNTRY?		
CN	11. MARITAL STATUS	Y U.S. ARMED	13. WAS DE		ANIC O	RIGIN? (Specify Yes		14. BACE	- American to	flen		
ВУ Е	1 Never Married 2 Married 3 Widowed 4 Divorced	2 NO ATES	If yes, ap	ecify Cuban, Mexic 2 g-NO Spec	can, Pu	erto Rican, etc.)		Black Speci	, White, etc.			
	15. DECEDENT'S EDU	CATION	44- 0505051111		23				Whit	:e		
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	16a. DECEDENT'S (Give kind of w life. Do NOT us	rork done durina mi	ost of working		16b. KIND OF BUS	INESS/INDI	USTRY			
1PL	12 yrs	Conege (I=4 or 5+)	Home	maker			Own I	Home				
8	17. FATHER'S NAME (First, Middle, Last)					AME (F	First, Middle, Melden	Surname)				
H	Phillip	Schmitt			Frieda		Meinke					
2	19a. INFORMANT'S NAME (Type/Print) Trudi. Carski						Number, City or Town			112		
	20a. METHOD OF DISPOSITION	200	PLACEANDDATE O			ka.	d. Baldwin, Md. 21013 DATE 20c. LOCATION — City or Town, State					
	1 St Buriet 2 Cremetton 3 Rem 4 Donation 5 Other (Specify)	oval from Stata com	retery, crematory or ot COSPECT I	her place)	eterv	7.						
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	-OSPECE I		ND ADDRESS OF F			3011,	Mary	Tark		
	14-6			Ruck	Towson I	une	eral Home	, In	C.		- 1	
Ruck Towson Funeral Home, In 1050 York Rd. Towson, Md. 21 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arr									204 eat,	Approxir	nate	
	interval Between IMMEDIATE CAUSE (Final disease or condition resulting in death) a. ACUVE STYPPINE											
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											
2	cause. Enter UNDERLYING CAUSE (Disease or injury	C										
Ē	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF);								
		J								1		
CAL	PART ii. Other aignificant condition	s contributing to death be	ut not resulting in	n the underlyin	g cause given in	n Part	I. 24a, WAS AN A PERFORI			WERE AUTOPSY AVAILABLE PRIOR	1 10	
ED							1 🗌 YES 2	NO		COMPLETION OF OF DEATH?		
PHYSICIAN: MEDIC	DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	F DEATH YE	S [] NO [UNCERTA	IN F	1			1 YES 2	NO	
SIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEAT	H (Check only one)								
YSI	1 - YES 2 NO	HOSPITAL: 1 Inputient 2 ER/Outp	atient 3 DOA	OTHER: 4 Divining Horn	e 5 🗆 Residence	6 🗆	Other (Specify)					
ВУ РН	27. MANNER OF DEATH Natural 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	JRY WO	URY AT PRK? YES 2 NO	28d	DESCRIBE HOW IN	JURY OCC	URED			
8	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, stc. (Spec	— At home, farm, st	treet, tactory, offic	•	261.	LOCATION (Street ar City or Town, Stete)	nd Number (or Rural R	oute Number,		
COMPLET		CIAN: To the best of my knowl								and menner as	stated.	
BE	296. SIGNATURE AND TITLE OF CERPHINE	la di in			29c. LICENSE NU	JMBER	267	29d. DATE	SIGNED	(Month, Day, Year		
2	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Print)				· Q			,	
		iladi 7600 Os			Md. 212	204	Suite 11	17				
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	ATURE			V-7	- WILL 1.					
	JUL 1 0 1995 Julia	Devotor Revell										

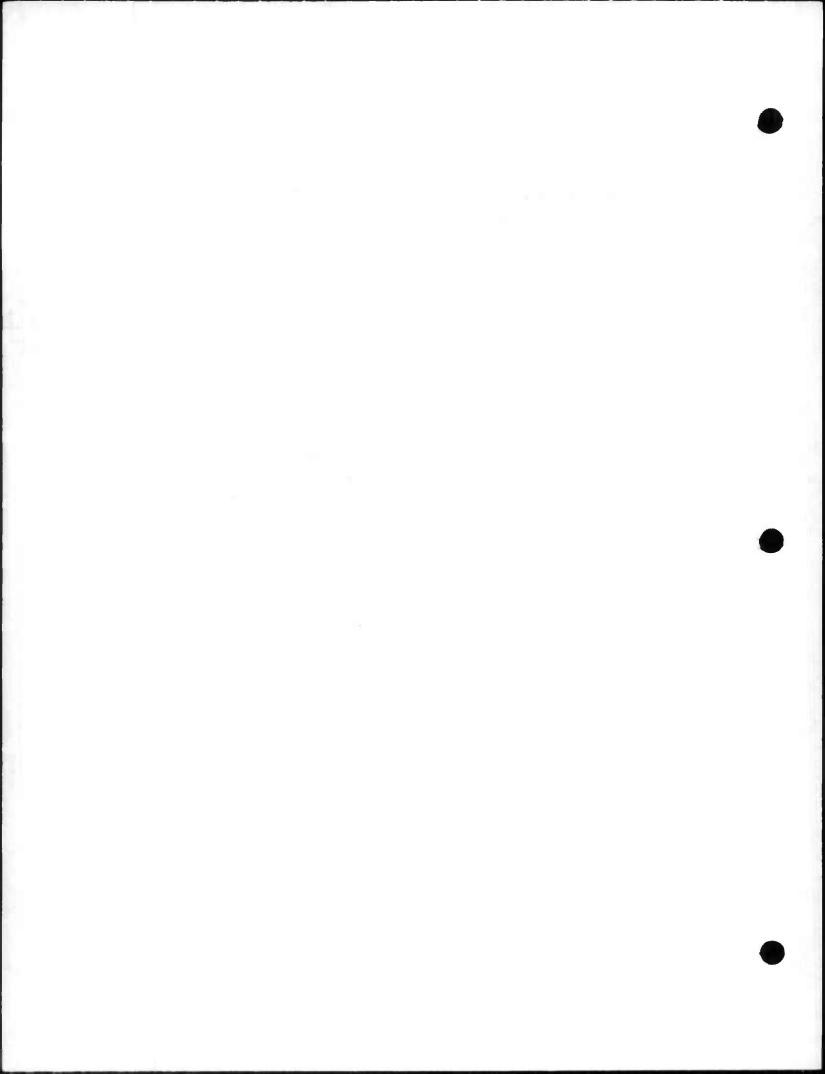


DIVISION OF VITAL RECORDS, P.O. BOX 68760

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ALLEN	ECTOR	s after	28
A G	AAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation	IMPORTANT If from 28 is marked or item 23 shows any injury or other traumatic event the medical eventual he continue as once
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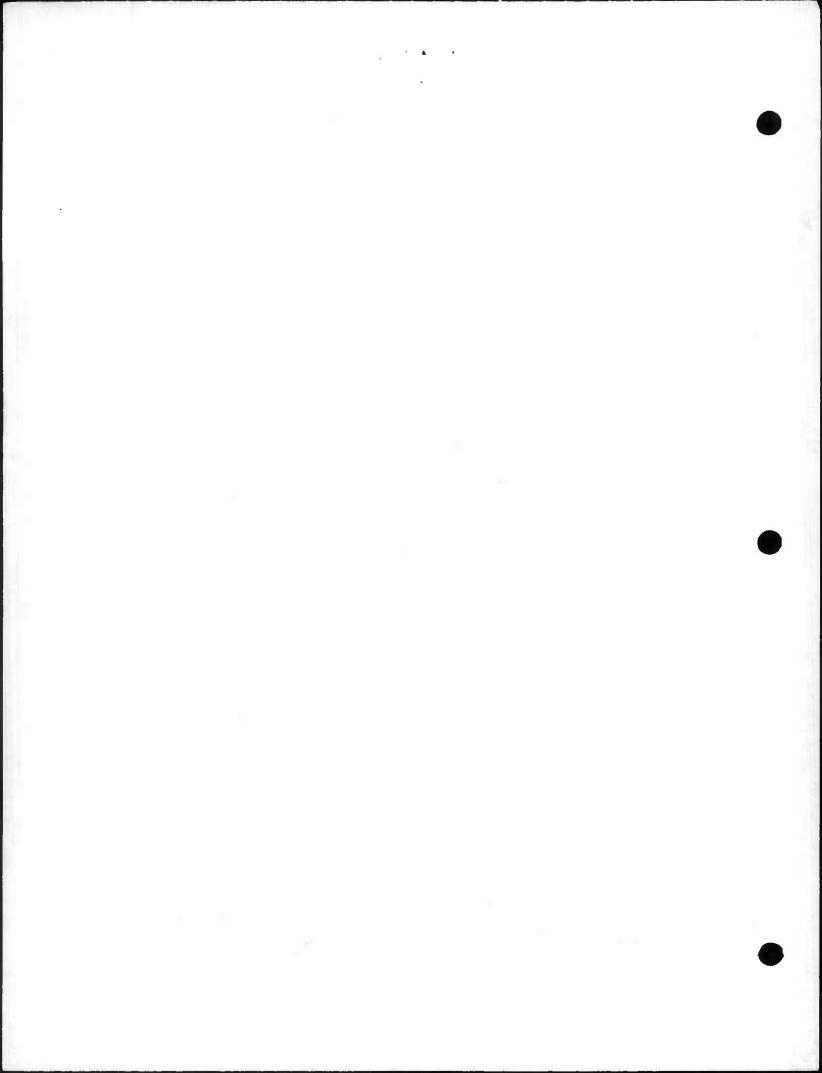
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	FOR 1 - STATE		STATE OF N						MENTAL HYGIEN	E			
	1. DECEDENT'S NAME (First	, Middle, Last)	Beni	anin	ERIIFI	CATE OF	DEA	++	2. DATE OF DEATH DATE OF D	ly .	YEAR 3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 213 16 95		5. SEX	6. AGE (In yrs. le:	t birthday)	IF UNDER 1 YEAR MONTHS DAYS		Admi	7. DATE OF BIFTH (Month, Day, Year) April 7,1	•	BIRTHPLACE (State or Foreign Country) New Jersey		
	9a. FACILITY NAME (If not in	9a. FACILITY NAME (If not institution, give street and number)					OR LOCATION				INTY OF DEATH		
DIRECTOR	RESIDENCE OF DEC		ndel 1	Hosp		tal Olen Burnie Annel					ine Arumel		
J. J.	Maryland Anne Arundel					TOWN OR LOC	ATION			10d. INSIDE CITY LIMITS?			
	10e. STREET AND NUMBER		e ALUIIUE	<u> </u>	Pasadena					1 ☐ YES 2 🎦 NO			
FUNERAL	8446 Chur	ch Roa	d		21122						J.S.A.		
F	11. MARITAL STATUS 1 Never Married 2 X	100	12. WAS DECEDENT FORCES? 1	EVER IN U.S. AF	R IN U.S. ARMED 13. WAS DECENDENT OF HISPAN ES 2 NO If yes, specify Cuben, Maxica			F HISPANI	C ORIGIN? (Specify Yes	14. RACE — American Indian, Black, White, etc.			
ВУ	3 Widowed 4 Divo		World	AR OR DATES			S 2 X NO				Specify: White		
ED	15. DEC	EDENT'S EDUC	ATION	16a. DE	CEDENT'S I	ISUAL OCCUPAT	TION	_	16b. KIND OF BUS	HNESS/INC			
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)					we kind of work done during most of working Do NOT use retired.) Heat Self					Cooling		
	17. FATHER'S NAME (First, M		rank Wes				18. MOTE		NE (First, Middle, Maiden	Surname)			
BE	19a. INFORMANT'S NAME (1		Lank wes	stcott	MAILING	ADDRESS (St.				oinsc			
2	Christine		ott			MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 146 Church Road Pasadena, Maryland 21122							
	20a. METNOD OF DISPOSIT		val from State	20b. PLACE	AND DATE O	F DISPOSITION (Vame of	Com			City or Town, State		
	4 Donation 5 Other 21. SIGNATURE OF FUNERA	(Specify)		Maryl	and S	State V				wnsv	ville, Maryland		
	21. SIGNATURE OF PUNERA	SERVICE LICE	:NSEE	St.		Georg		Gonc	e Funeral				
	22 BART I Enter the d	ien		NON	re	4001	Ritch	nie H	Mwy. Balt	imore	e, Md. 21225		
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Arthrosclerone Carclioves cules disease 10 %												
	resulting in death)	→ ,	DUE TO	OR AS A CONSE	OUENCE OF	car					case 10 gr		
CERTIFICATION	Sequentially list conditions, for any, leading to immediate But to (on as a consequence of): Actual on sell diabetes mellitas. But TO (on as a consequence of): Due TO (on a												
S	CAUSE (Disease or Inju	NG	SOVE		ese puence of	phrce	& va	30	ulas c	lise	2080, 10 yr		
R	that initiated events resulting in death) LAS	т	Diahol	IC nul	LA COLO	the							
	PART II Other elepitics	at conditions	nontelbutle - 40	1100	100	J							
PHYSICIAN: MEDICAL	PART II. Other significe	dec	usitus	ulce	esulting in	the underlyl	ng ceuse g	iven in F	Part I. 24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
Z	United er		elow 1		ani	1	ch'o	٠,			1 _ YES 2 _ NO		
AN	DID TOBACCO U		IBUIE IO CAI			(Check only one		ERTAIN					
SIC	EXAMINER?		HOSPITAL:			OTHER:		sidence 6	Other (Specify)				
E	27. MANNER OF DEATH		28a. DATE OF I (Month, Da		28b. TIME	OF 28c, IA	JURY AT		28d. DESCRIBE NOW IF	JURY OC	CURED		
BY	2 Accident	Pending Investigation	20. 51 405 05			M 1 🗆	YES 2						
ETED	3 Suicide 6 4 Homicide	me, farm, st	reet, factory, off	ca		28f. LOCATION (Street a City or Town, State)	nd Number	or Rural Route Number,					
COMPLET	29a. CERTIFIER (Check only one) 2 MEDI	TEYING PHYSIC	IAN: To the best	mination and/or i	ath occurred	at the time, dar , in my opinion,	e and place, death occur	and due to	o the cause(a) and men	ner se stat	ted, ne cause(a) and menner as stated.		
BE	296. SIGNATURE NO TITLE	S CENTIFIER	س	7	e	e MO	29c. LICE	NSE NUME	73	29d. DAT	E SIGNED (Month, Day, Year)		
٩	36. NAME AND ABBRESS OF		()		1 27) (Type, 1	Print)	01 7) ~ !!!	e 202,	WI	21061.		
	31. DATE FILED (MANITY, POS)		i it was	CIDEDANE II	343	HUSPIT	~ +	. 10	/	L	, 21001,		
	JULI UI	222 8	The Contract										

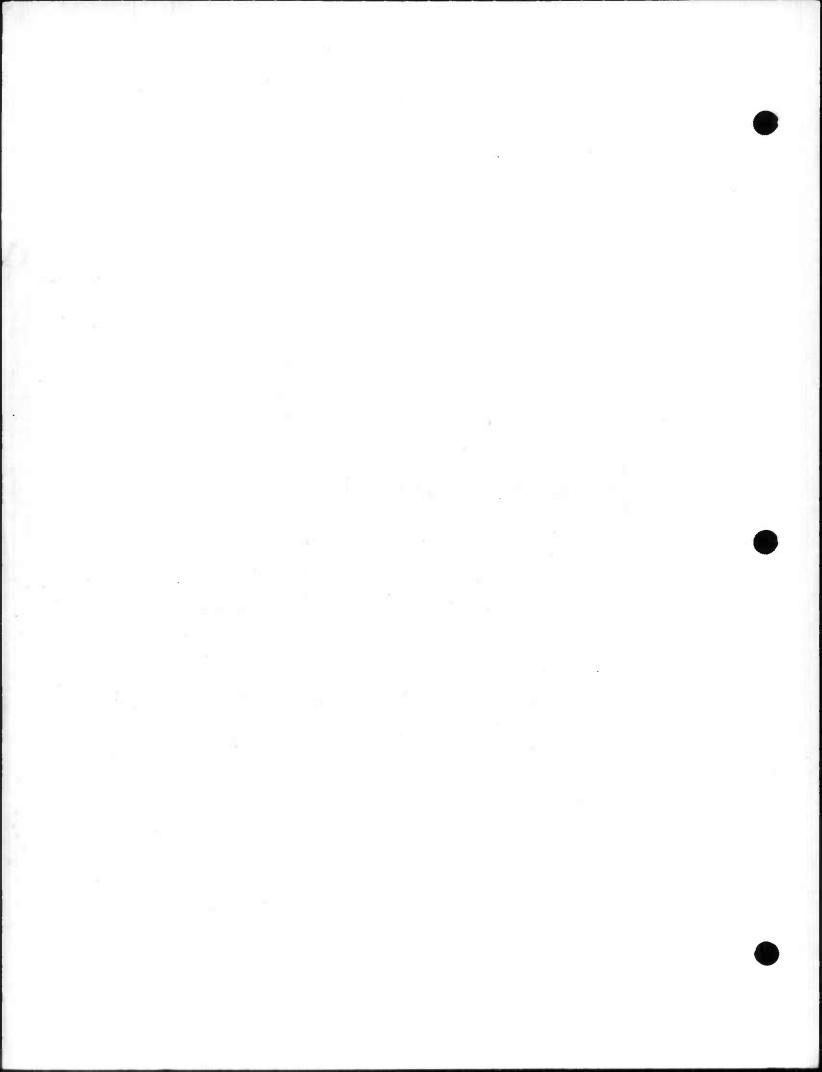


FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ANIE WEHNER 00:23 A M George JULY 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) B. BIRTHPLACE (State or Foreign 84 218-18-2980 1 M 2 - F Aug. 1910 Maryland Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give stree 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH St. Agnes Hospital DIRECTOR Baltimore N/A RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION IOd. INSIDE CITY Catonsville Maryland Baltimore 1 YES 2 X NO permit. FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE N. Beechwood Avenue U.S.A. 21228 use as the burial-transit retained by the hospital or attending physician. 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried 1 YES 2 NO Specify: Specify: White BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KINO OF BUSINESS/INOUSTRY (Specify only hig Elementary/Secondary (0-12) funeral director, page 5 should be detached for College (1-4 or 5+) 5+ General Surgeon Health Care 17. FATHER'S NAME (First, Middle Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) to George Wehner Christina Homberg BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 21228 Wehner N. Beechwood Avenue Baltimore, Maryland Grace (Spouse) 2 Pe 20a. METHOD OF DISPOSITION

1 🔀 Burlel 2 🗆 Cremation 3 🗆 Removal from State hours after death. Page 6 may 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must t DATE Oaklawn Cemetery July 10, 1995 Baltimore, Maryland 4 Donation 5 Other (Specify) _ 21. SIGNATURE OF FUMERAL SERVICE LICENSES medical examiner 22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes Lussewan 1630 Edmondson Avenue Catonsville Maryland in and completely filled in by the to burial, cremation, or removal. 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert fallure. List only one cause on each line intervel Batween IMMEDIATE CAUSE (Final Onset and Death the disease or condition resulting in death) Rend Failure event. DUE TO (OR AS A CONSEQUENCE OF): executed Aspirahou traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF). If any, leading to immediate that the death certificate be attending physician ntal Hygiene prior to Aizhaine cause. Enter UNDERLYING CAUSE (Disease or injury other OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 the atter PART ii. Other eignificent conditions contributing to death but not reaulting in the underlying ceuse given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY I Health and N shows any 1 YES 2 NO requires t OF DEATH? 1 | YES 2 | NO L. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN M OR ATTENDING PHYSICIAN: The law DIRECTOR: After this certificate has browns after death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Item EXAMINER? HOSPITAL: OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28e. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED marked. Natural 6 Pending 1 YES 2 NO BY Investigation 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 60 ETED 8 Could not be 4 Homicide 28 Hours Item 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. COMPL THE HOSPITAL O THE FUNERAL D filed within 72 ho TO THE HOSPITAL TO THE FUNERAL EDGE SILED WITHIN 72 HIMPORTANT: If II 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurs at the time, date and place, and due to the cause(e) and menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE une 7 1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STAGNES HOSPITAL 900 CATON ALE, BALT



		1 - FOR STATE REGISTRAR	TATE OF MARYLAND / DEPA CERTI	ARTMENT OF HEALTH AND FICATE OF DEATH	MENTAL HYGIENE REG. NO.						
	112411	1. DECEDENT'S NAME (First, Middle, Last)	lary L. H	Anderson	2. DATE OF DEATH MONTH DAY	YEAR 3. TIME OF DEATH					
P		DCH Q 1-1-0	SEX 8. AGE (In yrs. last birthday	MONTHS DAVE HOUSE ANN	7. DATE OF BIRTH (Month, Day, Year) June 26, 1927	B. BIRTNPLACE (State or Foreign Country)					
2, 3 should	OB	Sinai HUSnitul	ind number)	Baltmore		N A					
Pages 1,	DIRECTOR	10a. STATE 10b. COUNTY	NA 10c. C	ETY, TOWH OR LOCATION		10d. INSIDE CITY LIMITS?					
sit permit.	3AL	100. STREET AND NUMBER 4/2/ BOArman	Avenue	Daltimore 101. ZIP CODE	10g. CITIZI	1 1 2 YES 2 □ NO EN OF WHAT COUNTRY?					
5-0020 nding physician. Is the burial-transit	BY FUNER	11. MARITAL STATUS 12.	WAS DECEDENT EVER IN U.S. ABMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISP/ If yes, specify Cuben, Mexic 1 YES 2 (VNO Spec	en, Puerto Ricen, etc.)	4. RACE — American Indian, Black, White, atc. Specify:					
attend se as	ED	15. DECEDENT'S EDUCATIO (Specify only highest grade comp	(Give kind o	"S USUAL OCCUPATION of work done during most of working use retine(.)	186. KIND OF BUSINESS/INDU	STRY					
the hospital or detached for u	COMPLET	Elementary/Secondary (0-12) Co	NA HO	use wite	HOM-C AME (First, Middle, Malden Surname)						
retained by the 5 should be det	BE	Sam Willering 190, INFORMANT'S NAME (Type/Print)		Ada NG ADDRESS (Street and Number or Rural	Harkles	Confei					
RE, IV	TO	Jacqueline An	derson 4/2	1 Boarman F	DATE 200_LOCATION - CI	re, Nd 21215					
1 et e		1 Buriel 2 Cremation 3 Removal 1 4 Donation 7 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSE	Garn	Son Forest Uet 22, NAME AND ADDRESS OF F.	7/11/95 Qwings	1111 1					
M - 2 7		23. PART I. Inter the diseases, or comp	+ Jhmpsn J	R March 1- H	wabash the	Balto, Md znis					
24 hours y filled in t tion, or re the med		iMMEDIATE CAUSE (Finel disease or condition	Approximata Interval Between Onset and Death ARRUTHM A								
executed within and completely o burial, cremati matic event, ti	z	resulting in death)	DUE TO (OR AS A CONSEQUENCE	OP:	3, (MI-2	245)					
siclan prior t	ICATION	if any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUÊNCE OF): CONGESTIVE HORKET FAILURES									
death certifical death certifical attending phy ental Hygiene lary, or other	CERTIFIC	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE	OF):							
1 4 5 E	MEDICAL (PART II. Other significent conditions co	ntributing to death but not resulting	g In the underlying ceuse given in	Part I. 24s, WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE					
AL RECO he law requires the has been signed to Dept. of Health a		DID TOBACCO USE CONTRIBL	TE TO CAUSE OF DEATH	FALURE (ES NO XI UNCERTAL		OF DEATH? 1 YES 2 NO					
SICIAN: The law certificate has be the State Dept.	SICIAN:		26. PLACE OF DE	ATH (Check only one) OTHER:	8 Other (Specify)						
F H S	BY PHY	27. MANNER OF DEATH 1 Statural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year) 28b. Ti	IME OF 28c. INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCCU	RED					
OR ATTENDING DIRECTOR: After hours after death item 28 is ma	ETED	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — At home, larm building, etc. (Specify)	street, factory, office	281. LOCATION (Street and Number of City or Town, Stete)	Rural Route Number,					
	COMPL		To the best of my knowledge, death occur the basis of examination and/or investigat								
TO THE HOSPI TO THE FUNER De filed within	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER	amonto	29c LICENSE NU	MBER 29d. DATE :	GNED (Nonth-Ony, Year)					
1		30. HAME AND ADDRESS OF PERSON WHO CO	MPLET (D CAUSE OF DEATH (ITEM 27) (THE	Balto, md	. 15						
0		JUL 11 1995 Jul	SURGER PARTY OF THE COLUMN CO.								



TO BE COMPLETED BY FUNERAL DIRECTOR

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, compation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

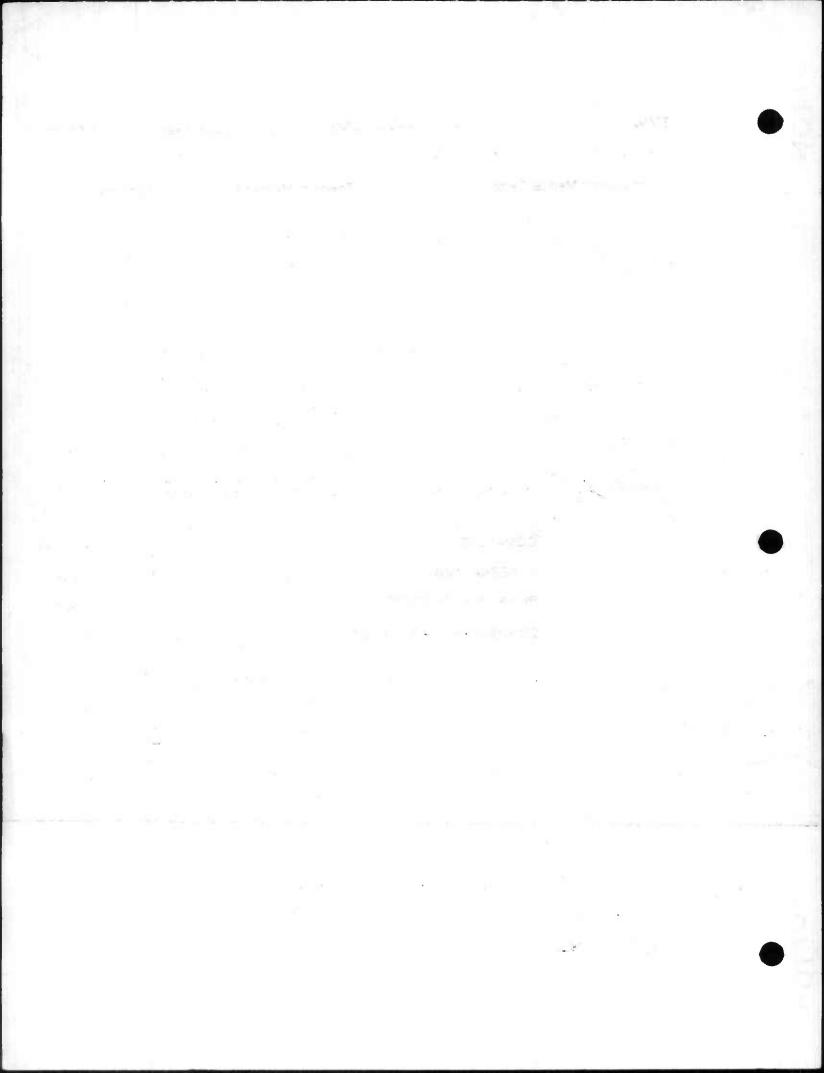
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1 - STATE REGISTRAR		STATE OF M	MARYLAN	D / DEPAI CERTIF					MENTAL HY	GIENE				
1. DECEDENT'S NAME (First	, Middle, Last)						-		2. DATE OF DEA	TN			3. TIME OF DEA	TN
CELE		AB	ELOFF						JULY 0	DAY	005	YEAR	10:08	
4. SOCIAL SECURITY NUME	BER	5. SEX		s. lest birthday)	IF UND	ER 1 YEAR	IF UNDER	1 24 HRS.	7. DATE OF BIRT			S. BIRTHE	LACE (State or Fi	A M
175-38-984	48	1 🗌 M 2 💢 F	88	YRS.	MONTH	DAYS	HOURS	MIN.	(Month, Day, Y March 18			Country)	
9a. FACILITY NAME (If not in	astitution, give st	reet and number)		9b. CITY, TOWN OR LOCATION OF DEATH								TY OF DE	isylvan:	Ld
THE JOHNS H	OPKINS	HOSPITA	L	BALTIMORE CITY					١	NA				
RESIDENCE OF DEC	10b, COUNTY													
Maryland		Baltimore		10c. CI	Y, TOWN	OR LOCAT						- 1	10d. INSIDE CITY LIMITS?	1
10e. STREET AND NUMBER		pallelmore							sville				1 - YES 2 1	NO
						79.17	ZIP COD		200	10			HAT COUNTRY?	
715 Maider	n Choic				-				228			J.S.	A.	
11. MARITAL STATUS 1 Never Married 2	Married	12. WAS DECEDEN FORCES? 1	T EVER IN U.S	ARMED 2NO	10	If yes, ap	ENDENT C	F NISPAI	NIC ORIGIN? (Spec	ify Yes or P	No- 1	14. RACE Black,	- American Indi Whita, etc.	én,
3 🔀 Widowed 4 🗌 Divo		IF YES, GIVE W	AR OR DATES			1 TYES				,		Specify	<i>r</i> :	
15. DEC	EDENT'S EDUC	CATION	140	. DECEDENT'S	LIGUAL	OCCI IDATIO	***		Lan Mana				White	
(Specify only	y highest grade	completed)		(Give kind of	work don	e dudaa ma	st of worki	ng	16b. KIND C	# BUSINE	SS/INDU	ISTRY		
Elementary/Secondary (0	1-12)	College (1-4 or 5 +)	Homer					Dom	esti	C			
17. FATNER'S NAME (First, M	liddle, Last)			TIOII	nane	1	18 MOT	MEB'S NA	ME (First, Middle, A					
	, ,	Ellois	Freid				io. mor		Lizabeth		,			
19a. INFORMANT'S NAME (7	Vpe/Print)		_	19b. MAILING	ADDRE	SS /Street a	nd Number		Route Number, City					
Dr. Mart		peloff							cimore, M)	- 1
20a. METHOD OF DISPOSIT	ION		20h PL	CEANDDATE	-			Dar		c. LOCATI				
1 Donation 5 Other		oval from Stata	cemeter	r, crematory or o	ther place	e)	ne or							
21. SIGNATURE OF FUNERA		ENSEE	Ch	isuk Pr		A. NAME AN	D ADDRE	SS OF FA		arrıs	sbur	G, PE	ennsylva	anıa
2.11	-10	02	11.							e Fur	nera	al Ho	ome, Inc.	
men	ace 1.	margue	40		9	11 N.	2nd	Stre	et Harr	isbu	rg, F	enns	sylvania	a
23. PART i. Enter the di	iseasee, or c	ompiications that Liet only one ceu	ceused the	deeth. Do	not ente	er the mo	de of dy	ing, auc	h ea cerdiac or	reapirato	bry arre	at,	Approxim	ata
IMMEDIATE CAUSE (Fin		. ,	oo on ouch	iii io.									Onset and	
diseese or condition resulting in death)	→	Electri	CAL	MEC	HAN	JICA	4	DISS	SOCIAT	INOI			MINS	
		DUE TO	OR AS A CO	NSEQUENCE O	F):									
		MALIG	NAN.	T VE,	NTR	ICUL	AR	TA	CHYCAI	RDIA	4		Mins	
Sequentially list conditi if any, leading to imme-	diete	A												
cause. Enter UNDERLY! CAUSE (Disease or inju	NG	. ACUTE	M	10 CAR	DIF	17	エヘ	1FA	RCTION				Mins.	
that initiated events reaulting in death) LAS		DUE TO	OR AS A CO	NSEQUENCE O	F):								110	
reading in death, LAS		LOR DI	VARY	AR	7E/	37	213	EA	SE				10 400	lrs
PART II. Other algnifica	nt conditions	s contributing to	death but r	ot resulting	in the u	ınderiving	cause o	iven in	Part i. 24a. W	AS AN AUTO	OPSY	24h 1	WERE AUTOPSY FI	NOINGS
	CANCE		TUS	POST	RI	GHT		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		RFORMED			AVAILABLE PRIOR	TO
HEMICOL				, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	/ \.				— ¹□¥	ES 2	NO		OF DEATH?	alust.
DID TOBACCO U		-	ISE OF F	EATLI VI	· c 🖂	NO E	11111	CDTA				1	1 YES 2	10
25. WAS CASE REFERRED TO		IBUIL TO CA		LACE OF DEA			UNC	ERTAI	4 LJ					
EXAMINER?	MEDICAL	HOSPITAL:			ОТНЕ	R:								
27. MANNER OF DEATH		1)2 Inpetiant 2 [_		sidenca	8 Other (Specify					
1 Netural 5	Pending Investigation	(Month, De		28b. TIN	JURY M	t Y] NO	28d. DEŞCRIBE I	IOW INJUR	HY OCCU	IRED		
3 Suicida 8	Could not be	28a. PLACE Of building,	ntc. (Specify)	it home, farm,	atreet, fa	ctory, offica			28f. LOCATION (S City or Town,		Vumber o	r Rural Ro	ute Number,	

BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION restigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) N003 D ઈ 0 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DEPARTMENT OF JULIA JOHNS HOPKINS TCHOU SURGERY HOSPITA 31. DATE FILED (Month, Day, Year)
JUL 1 1 1995

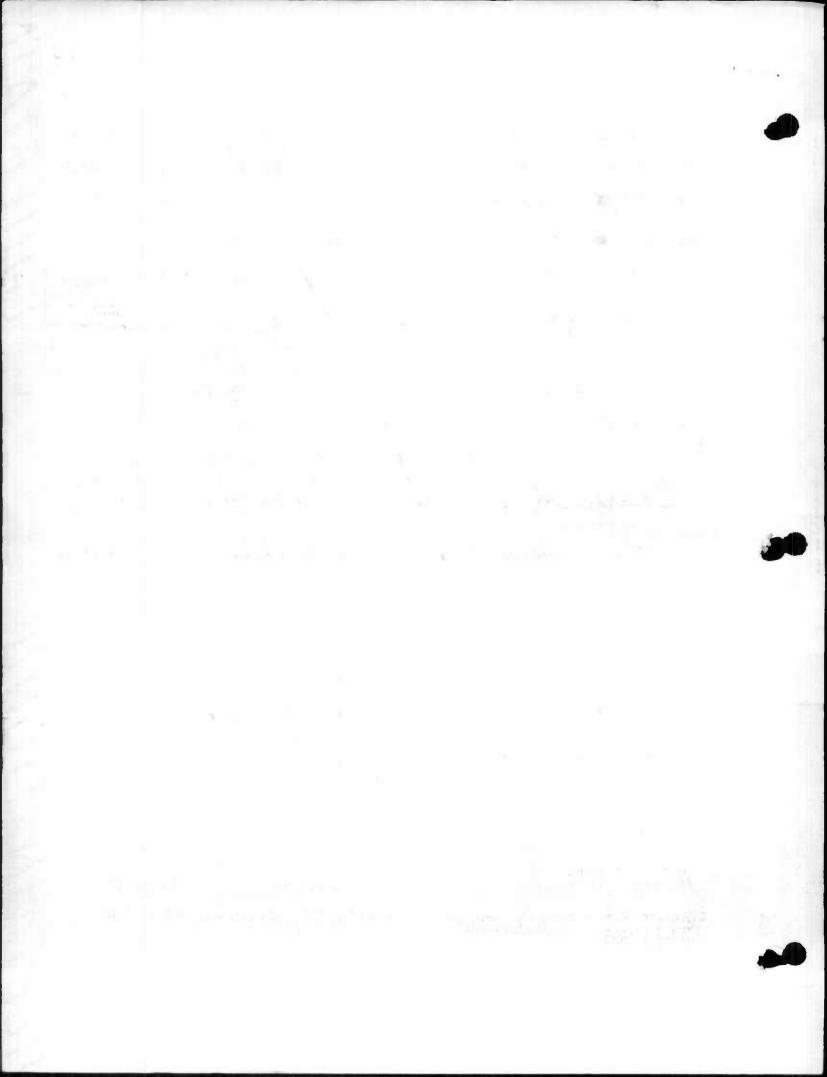
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	4
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	4

	REGISTRAR 1. DECEDENT'S NAME (First,	, Middle, Last)			OLITTI	ICATE	OI DE	-	REG. NO 2. DATE OF OEATH MONTH	AY	YEAR 3.	TIME OF DEATH
	EMMA					STRON			Jul 8 18			3:55 pm
	4. SOCIAL SECURITY NUMBER 215-03-886	57	5. SEX	6. AGE (In yrs	s. lest birthday) YRS.	IF UNDER 1 Y	EAR IF U	UNDER 24 HRS. URS MIN.	7. DATE OF BIRTH DEC. 26,	1915		land
~	9a. FACILITY NAME (If not in Saint Josep							CATION OF DE			NTY OF DEAT	
5	RESIDENCE OF DEC		AN CHILLE			10	owsor	ı, Maryl	and	B	altimore	
DIRECTOR	10e. STATE	10b. COUNTY				Y, TOWN OR I					10-	d. INSIDE CITY
	Maryland 100. STREET AND NUMBER	Balt	imore		M	iddle	Riv			T 40 - 0474	ZEN OF WHA	YES 2
ENAL	119 Rodeo	Circ	cle					1220			.S.A.	
	11. MARITAL STATUS 1 Never Married 2			T EVER IN U.S YES 2	NO	If ye	s, specify	ENT OF HISPAN Cuban, Mexica NO Specify	NC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	or No-	14. RACE — Black, W Specify:	American Indian, hita, etc.
	3 Widowed 4 Divo		NATION .	1000							1	White
2 2		EDENT'S EDUC y highest grade			(Give kind of life. Do NOT u	Work done during retired.)	PATION ng most of v	working	16b. KIND OF BUS	SINESS/IND	USTRY	
T I	8		College (1-4 or 5	*'	House	wife			Own Ho	ome		
ıl	17. FATHER'S NAME (First, M Henry F	rei					11112	MOTHER'S NA	ME (First, Middle, Meiden sa Garma			
0 8	190. INFORMANT'S NAME (T) Frank Arms		1						Route Number, City or Tow Baltimore			220
	20s set THOD OF DESPOSITI	ion in 3 🗆 Remo	oval from State	20b. PLA	CEANDDATE	OF DISPOSITIO	N (Name of			CATION	City or Town	State
- 1	4 Defiation 5 Dotter 21 SIGNATURE OF FUNERA		pesti	Garo	iens o	22. NAI	ME AND AD	DRESS OF FA	1/2/1995	Balt	imor	e, MD.
	Xapos	0	na						Funeral n Ave. Ba			
	21. ART I. Enter the di shock, or he AMMEDIATE CAUSE (Fin	eart jailuge.	proplications the	t caused the	death. Do line.	not enter the	mode of	f dying, suci	h as cardiac or reapi	ratory am	ent,	Approximate Interval Between Onset and Des
	disease or condition resulting in death)	+	COMATO	OR AS A COM	IS FOUR NO.	5						24 HOURS
5	Sequentially list conditi	lons I	HYPERK	ALEMIA								1 WEEK
	if any, leeding to immed cause. Enter UNDERLY!	dlate NG	RENAL I	VSUFFK	SEQUENCE O	F):						1 MONTH
CENTIFICATION	CAUSE (Disease or Inju that initiated events resulting in desth) LAS		CONGES	OR AS A CON		,						1 YEAR
3	PART II. Other algolfica	-4 did										· · · ·
MEDICAL	Diaber inforce	de,	Hypo	the	· C.	4.D.	N	14000		MED?	CO	RE AUTOPSY FINDING IILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES NO
Z Z	25. WAS CASE REFERRED TO		RIBUTE TO CA			TH (Check only		INCERTAIN	1			
2	1 YES NO		HOSPITAL:	ER/Outpatient	a 🗆 DOA	OTHER:	Home 5	Residence	8 Other (Specify)			
T PRISICIAN:		Pending Investigation	28e. DATE OF (Month, D	INJURY lay, Year)	26b. TIR	IURY	WORK?		28d. DESCRIBE HOW II	NJURY OCC	URED	
	3 Suicide 6	Could not be determined	28e. PLACE C building,	F INJURY — A	t home, ferm,				28f. LOCATION (Street e City or Town, Stete)	and Number	or Rural Route	Number,
			CIAN: To the best of	my knowledge	, death occurr	ed at the time,	date end p	place, and due	to the cause(e) end men	ner ee state	ed.	
	29e. CERTIFIER (Check only one) 2 MEDI	CAL EXAMINE	3: On the basis of a		tot maaatidatii	m, m my opini	on, destin o	occured at the	time, date and place, en	d due to the	cause(e) and	f menner ee stated.
	(Check only	CAL EXAMINER	3: On the basis of s	A STATE OF S	_	_	29c.	LICENSE NUM	IBER	29d. DATE	SIGNED (Mo	ngh. Day, Year)
BE COMPLETED	(Check only one) 2 MEDI	CAL EXAMINER	Dus	t00	5	\supset	1	1396	IBER	29d. DATE	SIGNED (Mo	ngh. Day, Year)
TO BE COMPLETED BY	(Check only one) 2 MEDI- 29b. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF	OF CENTIFIED PERSON WHO PRIST'	OOP, M.	SE OF DEATH O	TEM 277 (Types 3 Sh	Print)	D1	1396	altimore	17	191	ngh. Day, Year)



BALLIMORE, MARTLAND	Ikurs after death. Page 6 may be retained by the hos	d in by the funeral director, page 5 should be detach or removal.	the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 13146	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a steen death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and compared in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Heatth and Mental Hygiene prior to burial, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMEN	T OF H	DEAT	AND N	MENTA	L HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last) FRANCES VIRGIN	NIA ALDER						2. DATE MONT JUN		1995	PAR	3. TIME OF DEATH 1:00 A. M
	4. SOCIAL SECURITY NUMBER 2 19-20-3271	5. SEX 6. AGE ((In yrs. lest birthday) YRS.	IF UNDER	DAYS	IF UNDER :	24 HRS. MIN.	(Mont	of BIRTH th, Day, Year) . 23, 19	12	Coun	THPLACE (State or Foreign stry) T VIRGINIA
	9a. FACILITY NAME (If not institution, give st	2121 01		9b. CITY	r, TOWN C	R LOCATIO	N OF DE		. 23, 19	9c. COU		
5	WASHINGTON COUNT	TY HOSPITAL		HAC	GERS	TOWN						INGTON
ا تا	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	,	40.00									T
DIRECTOR		INGTON	19c. CI	TY, TOWN	ERST(10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	INGTON		IIAGI		ZIP CODE				10a. CITI	ZEN OF	1 X YES 2 NO
2	55 E. WASHINGTON	N STREET					740			U. S		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	N U.S. ARMED			ENDENT OF	F HISPAN		N? (Specify Yea		14. BAG	E - American Indian.
BY F	1 Never Merried 2 Merried 3 Widowed 4X Divorced	FORCES? 1 YES	ZYLXINO ATES			2 NO	Specify		Rican, atc.)		Spe	ck, White, atc.
						ΛΛ		100			Corp. III	WHITE
	15. DECEDENT'S EDUC (Specify only highest grade	completed)	(Give kind of life, Do NOT to	work done	during mo		7	161	b. KIND OF BUS	INESS/INC	OUSTRY	
2	Elementary/Secondary (0-12)	College (1-4 or 5+)	HOUSE						DAGM	AR HA	LL	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTH	ER'S NAI	ME (First,	Middle, Malden	Sumame)		
BEC	MADISON ODELL CU	JSTER				BE	SSI	E LE	E DeHA	VEN		
10 B	19a. INFORMANT'S NAME (Type/Print) PATSY J. WEIR								hber, City or Town			217/0
								L , H	AGERST			21740
	20e METHOD OF DISPOSITION 1 N Burlel 2 Cremetion 3 Rem	oval from State	other place) ERRARDST					CEM				Town, State
	4 □ Donation 6 □ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC		CKKAKDSI									N, WV
	+Charl.	M VS	10,14						ME, 32 INSBUR			G STREET
	23. PART I. Enter the diseases, pr	complications that cause	d the deeth. Do				-					Approximate
	shock, or heart failure.	List only one ceuse on e	ech iine.									Onset and Deeth
	disease or condition resulting in death)	· Acute/	Much	DIN	21.	1.01	Pap	1.	11/			4 HOURS
	readiting in destri)	DUE TO (OR AS /	CONSEQUENCE	OF):			7/(011	<i>O V</i>			1110000
Z	Sequentially list conditions,	b										
CERTIFICATION	if any, laeding to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	A CONSEQUENCE (OF):								
은	CAUSE (Disease or injury that initiated events	c DUE TO (OR AS /	A CONSEQUENCE (OF):								
	resulting in death) LAST	4										36
	DARK II ON THE INTERNATIONAL TO BE											
N S	PART II. Other algnificent condition	is contributing to death b	out not resulting	in the u	nderlyin	g cause g	iven in	Part i.	24a. WAS AN PERFOR		24	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
ă								_	1 TYES 2	(XNO	- 1	OF DEATH?
Σ								_				1 YES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL				24 DI	ACE OF DE	EATH /Ch	nok only o				
딣	EXAMINER?	HOSPITAL:	netlant 2 DOA	OTHE	R:							
PHYSICIAN: MEDI	27. MANNER OF DEATH	28e. DATE OF INJURY	26b. TI	ME OF	28c. INJ		sidence		SCRIBE HOW I	NJURY OC	CURED	
	1 Natural 5 Pending	(Month, Day, Year)	II.	JURY		YES 2	NO [
BÁ	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY building, etc. (Spec	/ — At home, ferm.	street, fac	tory, offic	•		28t. LO	CATION (Street of or Town, State)	nd Numbe	r or Rura	I Route Number,
	4 Homicide determined		//					Oil	or iown, dialoy			
COMPLETED		tCtAN: To the beat of my know	rledge, death occur	rred at the	time, date	and place,	end due	to the co	use(e) end me	ner se sta	ted.	
S	one) 2 MEDICAL EXAMINE	ER: On the basis of examination	on end/or investigat	ion, in my	opinion, d	leath occur	ed at the	time, dat	e end place, en	d due to ti	he ceuse	e(e) end menner ee stated.
BEC	286 SIGNATURE AND TITLE OF OURTHEE					29c. LICE			***			ED (Month, Day, Year)
2	WEEKY! "UN	National Association of the Control				DOC	004	- {		▶ 0	63	095
	30. NAME AND ADDITIESS OF PERSON WH	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Typ	Print)	I . A	ALL AN	15 11	No	DETALAL	1 1/4		1740
	EVARISTO R. LARD	LIZABAL, MOD	May 2	. 0151	EL	IND HI	F. +	MUE	N>10W	J, 111	0 00	1170
	JOLII 1992 De	- nedistrian s sidi	THI UNE									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

4	1	-	STATE REGISTR	AR
i	1	. D	ECEDENT'S	NAN

	HEGISTHAN		CERTIF	CALE OF	DEATH	REG. NO).	
1 3	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
1 3						MONTH I	DAY YEAR	
	KELVIN			BAB	RNES	JULY 9	, 1995	9:57 A M
1 3	4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (In yrs	last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRT	HPLACE (State or Foreign
	215-90-128411	MM2DF 27	YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year)	1010 ROY	(try)
	012011201	100	1110.			IJEDT, II,	1762 N	arviana
3	9a. FACILITY NAME (If not institution, give street	and number)		96. CITY, TOWN	OR LOCATION OF D	EATH /	9c. COUNTY OF	PEATH /
C			- 1				1//	Δ
2	MARYLAND GENERA	L HOSPITAL		BAI	TIMORE		/V/	Λ
DIRECTOR	10a. STATE , 10b. COUNTY	7						
1 2 1	IN. STATE	1/1	10c. CITY	TOWN OR LOCAT	TION			10d. INSIDE CITY LIMITS?
百	Maryland	VIH	1 /	Salti	mara.			1 PYES 2 NO
	10s. STREET AND NUMBER	11.		29111	11010			
%	2227	3. 01		101	. ZIP CODE	~	10g. CITIZEN OF	WHAT COUNTRY?
	12321 DIVIS	Inn ST.			2121	'/	1 (1	SA
FUNERAL	11. MARITAL STATUS	. WAS DECEDENT EVER IN U.S.	ADMED	12 WH C DEC	ENDENT OF WORK	NIC ORIGIN? (Specify Ye		
	1 Never Married 2 Married	FORCES? 1 YES 2	NO			in, Puerto Rican, atc.)	Bla	CE — American Indian, ck, White, atc.
B≼	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES			2 NO Specif		Spe	offy: 17/2 1/
	The mount of the process							BIACK
COMPLETED	15. DECEDENT'S EDUCATI		DECEDENT'S	USUAL OCCUPATION	ON	16h KIND OF BI	ISINESSANDUSTRY	019101
LEI	(Specify only highest grade con	npleted)		ork done during me			- 17-	
	Elementary/Secondary (0-12)	College (1-4 or 5+)	1110	2	1101		1//4	1
€	12		uni	2mpic	Vea	/	VIA	- 1
15	17. FATHER'S NAME (First, Middle, Last)				AS MOTHER'S NA	ME (First, Middle Maider	Silenama)	
	Shadnia H	Arnac			71	THE (THS), MINERAL MANUEL	1 Suprame)	
H	Drear C L	arnes			Ani	n lav	101	
1 1	19a INFORMANT'S NAME (Type/Print)	EL TOTAL S	19b. MAILING	ADDRESS (Street a	nd Number or Rural	Route Number City of Tox	vn, State, Zip Code)	
12	Ann Karnas	^	172	77.	Licial	LI	//	11 21210
1 1	MINI LATTE	>	± 22		VISIUN	1 27, 0	2/10/1V	10,2/2//
1 1	200 METHOD OF DISPOSITION	20b. PLA	CE AND DATEO	F DISPOSITION (No	me of	DATE 20c. LC	OCATION - City or 1	fown, State
1 1	1 🗹 Buriel 2 🗆 Cremation 3 🗆 Removal 4 🗆 Donation 5 🗀 Other (Specify)	from State cametery,	cretoptor or ou	net place)		7/12/2	and de	11100 MI
1 1			111	41011		1/3/95	<u> UNSUO</u>	une, Ma.
1 1	21. SIGNATURE OF FUNERAL SERVICE LICENS	iek () ()		22. NAME AN	O ADDRESS OF FA	GILITY	1	11.
1 1	D (h 10 L l	4 41.	1 . /	JOSE	ph L	KUSS FY	ineral	Home.
\Box	ANNER	dille	11	250	2 /1/ A	Mrth A	110 BA	1+n. Md. 2171/
	23. PART I Enter the diseases, or com	plications that caused the	deeth. Do n	ot enter the mo	de of dylng, auc	h sa cerdiec or men	Iretory armet	According
1 I	shock, or heart fallure. List	only one cause on each I	ine.		ac or cymg, eac	in all condiec or reap	matory arreat,	Approximate Interval Between
1 1	IMMEDIATE CAUSE (Finel							Onset and Death
	disease or condition	11111 51015 C	A (110	5 (AN ANC			
1 1	reaulting in death)	MULTIPLE G DUE TO (OR AS A CON	0103 1-1	1 4001	1111)			
1 1		DUE TO (OR AS A CON	SECUENCE OF):				
z								
0	Sequentially list conditions,	DUE TO (OR AS A CON	SEQUENCE OF)•				
151	if any, leading to immediate	10 (011110 11 0011	OL GOLINGE OF	<i>j</i> •				i I
CERTIFICATION	CAUSE (Disease or Injury							
	that initiated events	DUE TO (OR AS A CON	SEQUENCE OF):				
	resulting in death) LAST							
	d							
	PART II Other elgoiffeent conditions	antifliction to delete to a	A 122 2		ALC I CONTRACTOR			
l ₹ l	PART II. Other aignificent conditions of	ontributing to deeth but no	r resulting ii	the underlying	ceuse given in	Part I, 24a. WAS AN PERFO		b. WERE AUTOPSY FINDINGS
EDICAL								AVAILABLE PRIOR TO COMPLETION OF CAUSE
						1 NES	Z I NO	OF DEATH?
Σ								1 YES 2 NO
	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF D	EATH YE	SINO	UNCERTAIL	v \square \square		1
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			H (Check only one)	, OTTOLINA	,		
ᄓᇰᅵ	EV A SHAPE OF THE	OSPITAL:	ACE OF DEAT					
S		Inpatient 2 XER/Outpatient	3 DOA	OTHER: 4 Nursing Hom	e 5 🗆 Residence	6 Other (Specify)		
		28a. DATE OF INJURY	28b. TIME			28d. DESCRIBE HOW	IN HIEW OCCUPATION	
	27. MANNER OF DEATH		INJU	JRY WO	RK?	_		
0.		(Month, Day, Year)			ES 2 NO	Subje	TA SIL	
	1 Natural 5 Pending	Month, Day, Year)	084	ו □ו וויים כ	20 2 110	7- 220		*
₽	1 Netural 5 Pending 2 Accident Investigation	7 9 95 260. PLACE OF INJURY — AT		*				
₽	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	26e. PLACE OF INJURY — At building, atc. (Specify)		*		261. LOCATION (Street City or Town, State	and Number or Rural	
ED BY	1 Netural 5 Pending 2 Accident Investigation	7 9 95 260. PLACE OF INJURY — AT	home, farm, st	*		26f. LOCATION (Street	and Number or Rural	Route Number,
ED BY	1 Natural 5 Pending Investigation 3 Suicide 6 Could not be detarmined	26a. PLACE OF INJURY — At building, atc. (Specify)	home, farm, st	reet, factory, office	•	261. LOCATION (Street City or Town, State SOOBLK	and Number or Rural	
ED BY	1 Natural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29a. CERTIFIER (Check only) CERTIFYING PHYSICIAN	26a. PLACE OF INJURY — At building, atc. (Specify)	home, farm, st	reet, factory, office	and place, and due	261. LOCATION (Street City or Town, State 500 BLK.)	and Number or Rural	OPL BRUNCK
ED BY	1 Natural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29a. CERTIFIER (Check only) CERTIFYING PHYSICIAN	26a. PLACE OF INJURY — At building, atc. (Specify)	home, farm, st	reet, factory, office	and place, and due	261. LOCATION (Street City or Town, State 500 BLK.)	and Number or Rural	OPL BRUNCK
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ORDS, P.	

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. A hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If New 28 is marked on list and 13 shours any inliner or other trainmable event, the madical examiner must be marked at once. YLAND 21215-0020 DIVISION OF VITAL REC

	ITEM: 1. PER F.H. FILM G	i-725 7/11/95 t	:.t			90	208 20
	1 - FOR STATE REGISTRAR	E OF MARYLAND	DEPART	MENT OF HEALTH AND	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last) HENRY	FRANCIS BURNS			2. DATE OF DEATH	AV V	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. In	at hirthday)	IF UNDER 1 YEAR	7 DATE OF BURTH	395	9,04 7 _M BIRTHPLACE (State or Foreign
	213-01-4289 ¹፟፟፟፟™			HONTHS DAYS HOURS MIN.	(Month, Day, Year) Sept.3,19	008 M	Country) (aryland
_	9a. FACILITY NAME (If not institution, give street and nu Keswick Home	imber)		96. CITY, TOWN OR LOCATION OF D		9c. COUNTY	
Ĕ	RESIDENCE OF DECEDENT			Darchiore		Daiti	more city
DIRECTOR	Maryland Baltimore	City		TOWN OR LOCATION 1timore			10d. INSIDE CITY VIMITS? 1 XYES 2 NO
	10e. STREET AND NUMBER			101, ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
FUNERAL	1232 Union Avenue			21211		USA	
5	1 Never Married 2 XXMarried FORC	DECEDENT EVER IN U.S. AU CES? 1 YES 2 TO S. GIVE WAR OR DATES	NO	13. WAS DECENDENT OF HISPA If yea, specify Cuban, Mexic	an, Puarto Rican, aic.)	s or No— 14.	RACE — American Indian, Black, Whita, atc.
ЭВУ	3 Widowed 4 Divorced	S, GIVE WAR ON DATES		1 Tes 2X NO Speci	/y:		White
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College	(6	ECEDENT'S U Sive kind of wo a. Do NOT use	SUAL OCCUPATION rk done during most of working retired.)	16b. KIND OF BU	SINESS/INDUST	TRY
M P	10		Acco	ountant			ounting Firm
TO BE COM	17. FATHER'S NAME (First, Middle, Lest) Henry Reese Burns				ME (First, Middle, Malden Mary Rob	ey	
TO TO	190. INFORMANT'S NAME (Typo/Print) Catherine Burns	19	1232 T	COORESS (Street and Number or Rural Union Avenue, E	Aoute Number, City or Tow altimore,	n, State, Zip Coo Marylai	nd 21211
must o	20a. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Removal from	State cemetery, cre	emelory or othe	DISPOSITION (Name of er piece)	1	CATION — City	
191	4 ☐ Donallon 5 ☐ Other (Specify) 21. SIGNATURE, OF FUNERAL SERVICE LICENSEE	Woo	dlawn	Cemetery 22. NAME AND ADDRESS OF FA		dlawn,	Maryland
THE STATE OF THE S	June Henry	Carpente	1	Burgee-Henss			1211
000	23. PART I. Enter the disesses, or complicet	lons the csused the de	eeth. Do no	13631 Falls Ro	ad. Baltim	ore, Ma	aryland
					at an entailed of teab	natory sirest,	, Approximats
	shock, or heert fellure. List only IMMEDIATE CAUSE (Final	One cause on each line	B.		in so condition of resp.	ratory sirest,	Interval Between Onset and Death
1110		sheimer!	·.	lisease.		matory sirest,	Interval Between
N	IMMEDIATE CAUSE (Final disease or condition resulting in death)	She cause on each line	·.		are continue of resp.	natory sirest,	Interval Between
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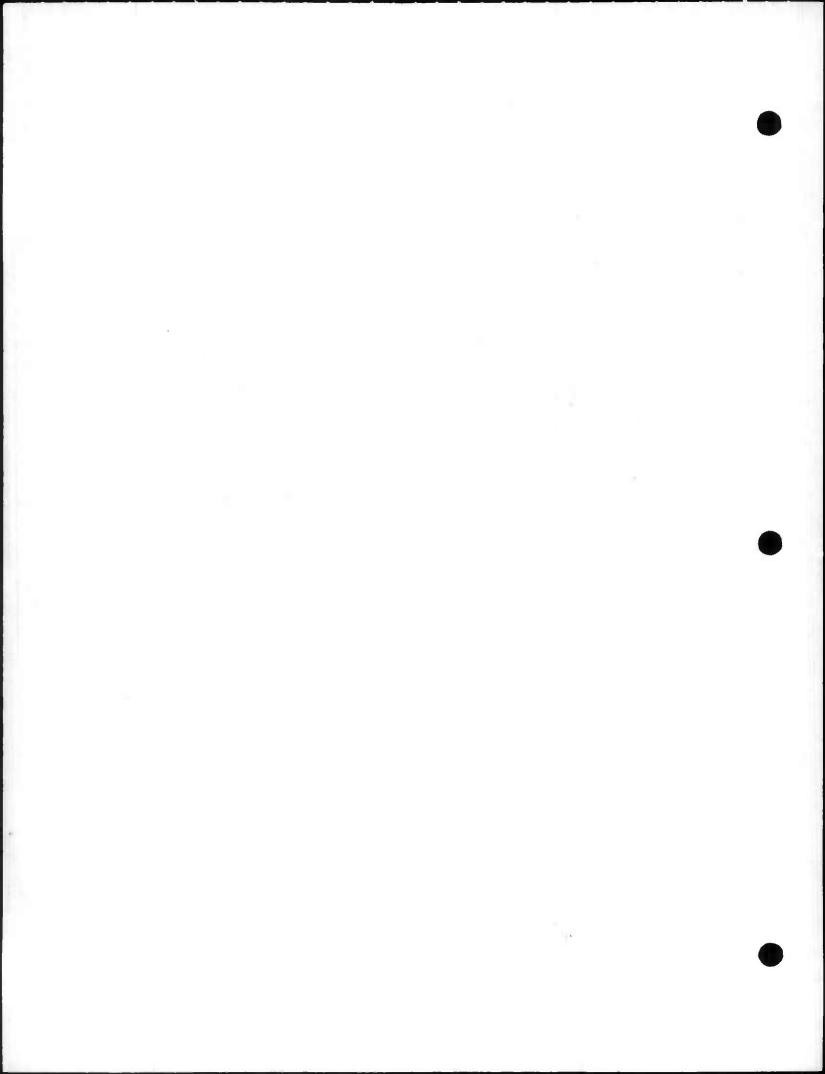


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 5 should be detached for use as the burial-trans

	1 - STATE REGISTRAR	STATE OF MARYLAN	ND / DEPARTM			MENTAL	HYGIENE REG. NO.	Ē	
	1. DECEDENT'S NAME (First, Middle, Las	Bagowitz				Jul)	/ 5		3. TIME OF DEATH
	Unknown	5. SEX 8. AGE (In)	MOI	UNDER 1 YEAR VTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	(Month	DE BIRTH Day, Year) 02-33	0.	BIRTHPLACE (State or Foreign Country)
Œ	9a. FACILITY NAME (If not institution, give	street and number)			R LOCATION OF DE			9c. COUNTY	OF DEATH
СТО	Liberty Medica			Balti				r	ı/a
DIRECTOR	10a. STATE 10b. COUN	n/a		ltimor					10d. INSIDE CITY LIMITS? ▼ YES 2 NO
	10e. STREET AND NUMBER		200		ZIP CODE			10g. CITIZEI	N OF WHAT COUNTRY?
FUNERAL	2911 Allen Roa	ad Baltimore,			21216 ENDENT OF HISPAN			U.	S.A.
BY	1 Never Married 2 Married 3 Widowed 4 XDivorced	FORCES? 1 YES	2- NO	If yes, spe 1 YES	cify Cuban, Maxica	n, Puerto R	r (Specify Tes licen, etc.)	or No.— 14	. RACE — American Indian, Black, White, etc. Specify: Black
COMPLETED	15. DECEDENT'S EL (Specify only highest gra Elementary/Secondary (0-12)		6a. DECEDENT'S USU (Give kind of work life. Do NOT use ref	done during mos lired.)	N st of working	16b.	KINO OF BUS		
DMP	12 17. FATHER'S NAME (First, Middle, Last)		domes	tic	16. MOTHER'S NA	ME (First 1)	privat		les
ш	Thomas Myrick						Worsle		
TO B	19a. INFORMANT'S NAME (Type/Print) Josephine Myricl				nd Number or Rural F				
	20a, METHOD OF DISPOSITION	20h BI	201 No:			W1111	amstor		7892 y or Town, State
	1 M Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State cameta	ary, crematory or other p	oleca) rial Ga	ardens				ton NC 27892
	21. SIGNATURE OF FUNERAL SERVICE	Starte		Ster	Ling Asht	ton F	uneral	L Home	
CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that inflated eventa resulting in death) LAST	a. Metasta DUE TO (OR AS A CO DUE TO (OR AS A CO DUE TO (OR AS A CO DUE TO (OR AS A CO DUE TO (OR AS A CO DUE TO (OR AS A CO DUE TO (OR AS A CO DUE TO (OR AS A CO	onsequence of: cytopen onsequence of: cytopen onsequence of:		Cance				interval Between Onset and Death YV
MEDICAL	PART II. Other algorificant condition	is im				Part 1.	24a. WAS AN A PERFORM	NEO3	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN:	DID TOBACCO USE CON 25. WAS CASE REFERRIZO TO MEDICAL	·	DEATH YES		UNCERTAIN	1 🗆 📗			
SIC	EXAMINER?	HOSPITAL: 1 D Inpatient 2 D ER/Outpatie	ОТ	HER:	5 Residence	8 🗆 Other	(Specify)		
	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	WOI	RK?	28d. DEŞ	CRIBE HOW IN	JURY OCCUP	RED
red BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e PLACE OF INJURY -	At home, farm, street		ES 2 NO		TION (Street and Town, State)	nd Number or	Rural Route Number,
COMPLETE		SICIAN: To the best of my knowledger: On the basis of examination are							ause(a) and manner as state-4
BE	296 SIGNATURE AND TITLE OF CERTIFI		D.		29c, LICENSE NUM				IGNED (Month, Day, Year)
0	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DEATH	2600	"Libe	uty t	leig	hts	Ave	21215
Ì	31. DATE FILED (Mohilin, Day, Year)	SZ REGISTRAR'S SIGNAT	atlall						



2:

106. INSIDE CITY LIMITS?

1 TYES 2 1 1 NO

Onset and Death

Ws

24L WERE AUTOPSY FINDINGS AMILABLE PRIOR TO

OF DEATH?

COMPLETION OF CAUSE

1 TYES 2 NO

Maryland

Carroll

10g. CITIZEN OF WHAT COUNTRY?

United States

14. RACE — American Indian, Black, White, etc.

Specify Black

Sc. COUNTY OF DEATH

BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

Carlton Edward Berry

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7, DATE OF BIRTH m Day DAYS TWM 2 DF Dec. 69 YRS. 212-20-2043 Se. FACILITY NAME (If not institution, give arest and number) 96. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Pages 1, 2, 3 7721 Carter Road Sykesville RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Carroll Svkesville permit. 3 10s. STREET AND NUMBER FUNERAL 101. ZIP CODE 7721 Carter Road burial-transf 21784 Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 \(\subseteq YES 2 \(\subseteq SNO \) Specify: 1 Never Married 2 50 Married FORCES7 1 0 YES 2 NO IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced page 5 should be detached for use as the COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working the, Do NOT use retrad.) IS. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) 11th grade Ret: Security Guard Patuxent Institution once. 17. FATHER'S NAME (First, Middle, Land) 18. MOTHER'S NAME (First, Missle, Malder Suman notified at Wilmer Berry Frances Dorsey BE 194. INFORMANT'S NAME (Type/Print) 19b, MAILING ADDRESS (Street and Number or Rural Route Number, City or Tiven, State, Zip Code) 2 Mrs. Helen E. Berry 7721 Carter Road Sykesville, MD 2 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION / Name of DATE 29c. LOCATION -- City or Town, State Must 1 St Burial 2 □ Cremation 3 □ Res 4 □ Donation 5 □ Other (Specify) the funeral director, MD Veterans Cemetery 7/10 Garrison Forest, MD 21. SIGNATURE OF TIMERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Burrier-Queen Funeral Directors, P.A. examiner other death. veus Lemes 1212 W. Old Liberty Rd. Winfield, MD 21784 Inmoval medical 23. PART J. Enjer the diseases, or complications that cause ster the mode of dying, such as cardiac or respiratory arrest, filled in by shock, or heart failure. List or Ay oné ö IMMEDIATE CAUSE (Final 朝 cremation. theroselevolve disease or condition resulting in death) completely other traumatic event, DUE TO (OR AS A CONSEQUENCE OF) buriar, CERTIFICATION R Sequentially list conditions, DUE TO (OW AS A CONSEQUENCE OF) prior to If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): the attending p Mental Hydian that initiated events resulting in death) LAST 6 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY signed by the any 1 YES 2 NO Shows peed 6 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN Dept by PHYSICIAN: 13 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Ch Hem certificate h **EXAMINER?** HOSPITAL YES 2 NO 1 ☐ Inputient 2 ☐ ER/Outpetient 3 ☐ DOA me 5 Plesidence 6 - Other (Specify) 941 6 MANNER OF DEATH 28s. DATE OF INJURY 28c, INJURY AT WORK? 25b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED that the marked. Netural Accident 1 YES 2 NO BY Affect 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) ä 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED DIRECTOR. 22 4 Homicide them 29a. CERTIFIER 1 CERTS-VING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. FUNERAL WITH 72 I = TO THE HOSPID TO THE FUNERA De fled within 7 BE 2 PLETED GAUSE OF DEATH (ITEM 27) (Type, Print)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

IF UNDER 1 YEAR

6. AGE (in you last birthday)

DOVIU

MONTH

1925

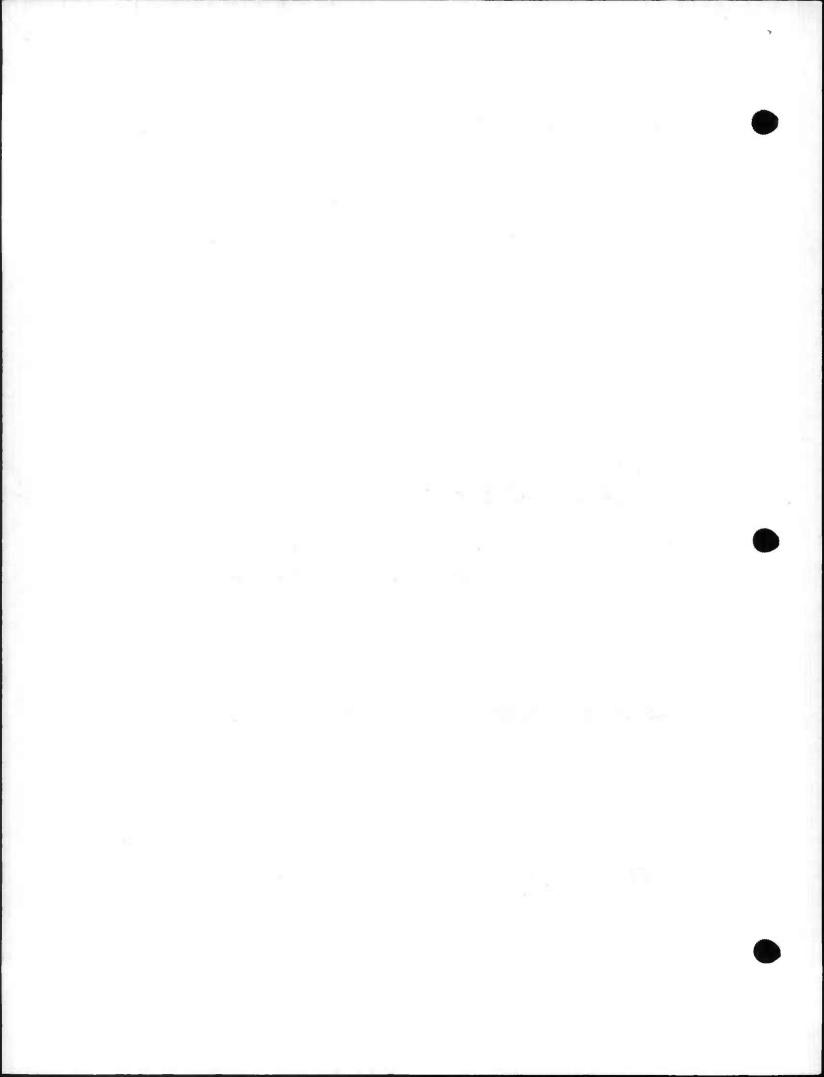
DHMH-16 Rev 1/89

JUL 1 1 1995

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should	nation, or removal.	od, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certifical	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending phy	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTMEN			MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)	2	uVai			2. DATE OF GEATN		3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. Id		DER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN	7.5	BIRTHPLACE (State or Foreign
	367-07-7855	1 ☑ M 2 □ F 80	YRS. MONTH		HOURS MIN.	Feb. 6, 1	915	Country) Michigan
R	so. FACILITY NAME (If not institution, give structure) Golden Age Guest		9b. CI		R LOCATION OF DI SVIlle	EATH	9c. COUNTY	of DEATH arroll
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	TOMO	10c. CITY, TOWN					
DIRE		roll	ATT OF THE REAL PROPERTY.	rsburg				10d. INSIDE CITY LIMITS? 1 YES 2 XNO
	10e. STREET AND NUMBER		101401		ZIP CODE		10g, CITIZEN	OF WHAT COUNTRY?
FUNERAL	6165 Washita Road				21784		Unite	d States
BY FU	11. MARITAL STATUS 1 Never Merried 2 Merried 3 M Widowed 4 Divorced	12. WAS OECEDENT EVER IN U.S. A FORCES? 1 YES 2 X IF YES, GIVE WAR OR DATES		If yes, spe		NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.) y:	s or No- 14.	RACE — American Indian, Black, White, etc. Specify: White
	15. OECEDENT'S EDUCA (Specify only highest grade of		ECEDENT'S USUAL Give kind of work don	OCCUPATIO	N t of working	16b. KIND OF BU	SINESS/INDUST	
COMPLETED	Elementary/Secondary (0-12) 10th grade	College (1-4 or 5 +)	le. Do NOT use retired	1.)	o working			
M	17. FATNER'S NAME (First, Middle, Last)	,	Ret: C1	erk	40 4405145010 144		Motor	Co.
	David Beauvais			- 5	unknov	ME (First, Middle, Maiden	Surname)	
) BE	19e. INFORMANT'S NAME (Type/Print)	1	9b. MAILING ADDRE	SS (Street ar		Route Number, City or Tow	vn, Stele, Zip Co	de)
5	Mr. James Beauvais	3	6165 Wa	shita	Road I	Eldersburg	, Maryl	land 21784
	20e. METHOD OF DISPOSITION M☐ Burial 2 ☐ Cremation 3 ☐ Remo	val from State 20b. PLACE	AND DATE OF DISP	OSITION (Nar	West	DATE 20c. LO	CATION - CITY	or Town, State
	4 Donation Other (Specify)	NSEE C CAd1	llac Mem	Orial 2. NAME AN	Gardens ADDRESS OF FA	5 7/12 Wes	stland,	Michigan
	· Comme	B COTH						ors, P.A.21784
	23. PART & Enter the diseasea, pr co	emplications that caused the d	sally. Do not ent	er the mod	W. Old I	iberty Roa	ad Wir	nfield, MD
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	ist only one cause on each fin	ha suu					Interval Between Onset and Death
_		DUE TO (OR AS A CONSI	SLAMO!	1500	(EMP	YEAR)		
2	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSI	10					
S	cause. Enter UNDERLYING CAUSE (Disease or injury	·						
CERTIFICATION	that initiated events reaulting in death) LAST	DUE TO (OR AS A CONSI	EQUENCE OF):					
	DART II OAL - clastification and distance							
DICAL	PART II. Other significent conditions	contributing to deeth but not	resulting in the	underlying	ceuse given in	Pert I. 24a. WAS AN PERFOI	RMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
M	DID TOBACCO USE (CONTRIBUTE TO CA	UCE OF DE	A T 1 1 1				1 TES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL	JONIKIBUTE TO CA	USE OF DE		CE OF DEATH (Ch	- 44		
SIC		HOSPITAL: 1 Inpatient 2 ER/Outpatient	3 DOA 4 TH	ER:		6 Other (Specify)		
PHYSICIAN: MEDIC	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJU	RY AT	28d. DESCRIBE NOW	INJURY OCCUR	ED
BY	1 Natural 5 Pending 2 Accident Investigation		M	1 🗆 Y	ES 2 NO			
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At h building, atc. (Specify)	ome, larm, street, la	actory, office		281. LOCATION (Street City or Town, Stete)		Rural Route Number,
COMPLETED		CIAN: To the best of my knowledge, of the besis of exemination end/or						suse(e) end menner es stated.
H	296. SIGNATURE AND THAT OF CERTIFIER	Aus			29c. LICENSE NUI	MBER 06	29d. DATE SI	GIVED (Modity Day, Year)
임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH (IT	EM 27) (Type, Print)	iber	Ly Rose		*/	
	31. DATE FUED (MOOF). 1993 Ju	A 35 TERRITOR POR PORTOR		001	/			



DIVISION OF VITAL RECORDS. P.O. BOX 68760.

R ATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL H	IYGIEN
GISTRAR	CERTIFICATE OF DEATH	REG. NO

1	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH DONTH D	AY YE	3. TIME OF DEATH
	Donald Richard 4. SOCIAL SECURITY NUMBER 5. SEX	Buchholz 8. AGE (In yrs. lest birthde				1995	1510
	220-20-6418 1 St 2 = F	6.7 YRS	MONTHS DAYS	IF UNDER 24 HRS, HOURS MIN.	7. DATE OF BIFTIN (Month, Day, Year) NOV • 5 , 19	27	BIRTNPLACE (State or Fore Country) Maryland
	9a. FACILITY NAME (If not institution, give street and number)	07		OR LOCATION OF DE		9c, COUNTY	
e o	719 S. 49th Stree	et	Ba	ltimore			altimore
DIRECTO	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	100	CITY, TOWN OR LOCA	TION			10d. INSIDE CITY
E .	Md. Baltimon			1timore			LIMITS?
	10e. STREET AND NUMBER			f. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
FUNERAL	719 S. 49th Street			212	24	l t	USA
Į.	1 Name Married 2 Married FORCES?	NT EVER IN U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	IC ORIGIN? (Specify Year, Puerto Ricen, stc.)	or No 14.	RACE — American Indian Black, White, etc.
BY	3 Widowed 4 Divorced IF YES, GIVE	WAR OR DATES	1 🗌 YES	NO Specify			Specify: White
G	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	18a. DECEDEN	T'S USUAL OCCUPATION	ON	16b, KIND OF BU	SINESS/INDUST	
Ē	Elementary/Secondary (0-12) College (1-4 or s	5+)	of work done during mo T use retired.)	ost or working			
COMPLET	9th 17. FATNER'S NAME (First, Middle, Last)	Shee	t Metal	I		eth St	teel
CC	Max Buchholz				ME (First, Middle, Maiden na Treef	Surname)	
00	19a. INFORMANT'S NAME (Type/Print)	19b. MAILI	ING ADDRESS (Street a		Route Number, City or Tow	n, State, Zip Coo	fe)
2	Donald Buchholz	71	9 S. 49	th Stre	et Balti	more 1	Md. 21224
	20a. METHOD OF DISPOSITION 1 □XBurial 2 □ Cremation 3 □ Removal from State		TE OF DISPOSITION (Ne			CATION — City	
	4 Donation 5 Other (Specify)	Oak Ĺ	awn Cem		/11/95 B	altimo	ore Md.
	1) SIGNATURE OF FUNERAL SERVICE LICENSEE	11		ND ADDRESS OF FAC	uneral H	Ome of	f Essex
_	1. Imy (a	nnellil					
	23. PART I. Enter the diseases, or complications the shock, or heart failure: LIST only one commendate CAUSE (Final	nat caused the death Dauee on each line.	● mot enter the mo	Mace A	ve. Balt	imore Iratory arrest,	Approxima Interval Be
ERTIFICATION	shock, or heert failure. List only one companies of the condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury cause.	o (OR AS A CONSEQUENCE	Gundh:	ode of dylng, such	me Balt	imore fratory arrest, head	Approxima Interval Be
MEDICAL CERTIFI	shock, or heert failure. List only one companies of the condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente	O (OR AS A CONSEQUENCE O (OR AS A CONSEQUENCE O (OR AS A CONSEQUENCE	OF):	of Wow	n as cardiac or respi	Lea d	Approximatinterval Be Onset end 24b. WERE AUTOPSY FIN AMILLABLE PRIOR TO COMPLETION OF CA OF DEATH?
MEDICAL CERTIFI	shock, or heert failure. List only one of immediate cause or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated evente resulting in death) LAST DID TOBACCO USE CONTRIBUT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	O (OR AS A CONSEQUENCE O (OR AS A CONSEQUENCE O (OR AS A CONSEQUENCE	OF): OF): OF): OF): OF DEATH Y 28. PI	de of dying, such	Part I. 24a. WAS AN PERFO!	Lea d	Approxima interval Be Onset end Onset end 24b. WERE AUTOPSY FIN AMILABLE PRIOR TO COMPLETION OF CU OF DEATH?
MEDICAL CERTIFI	shock, or heert failure. List only one of immediate cause or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST DID TOBACCO USE CONTRIBUT 25. WAS CASE REFERRED TO MEDICAL RAMINER? 1 YES 2 NO HOSPITAL: 1 Inpatiant 2	O (OR AS A CONSEQUENCE O (OR AS A CONSEQUENCE O (OR AS A CONSEQUENCE O (OR AS A CONSEQUENCE O deeth but not resulting	F DEATH Y 26. PI OTHER: 4 □ Nursing Nor	g ceuse given in	Part I. 24a. WAS AN PERFOR I YES 2	AUTOPSY MED?	Approxima interval Be Onset end Onse
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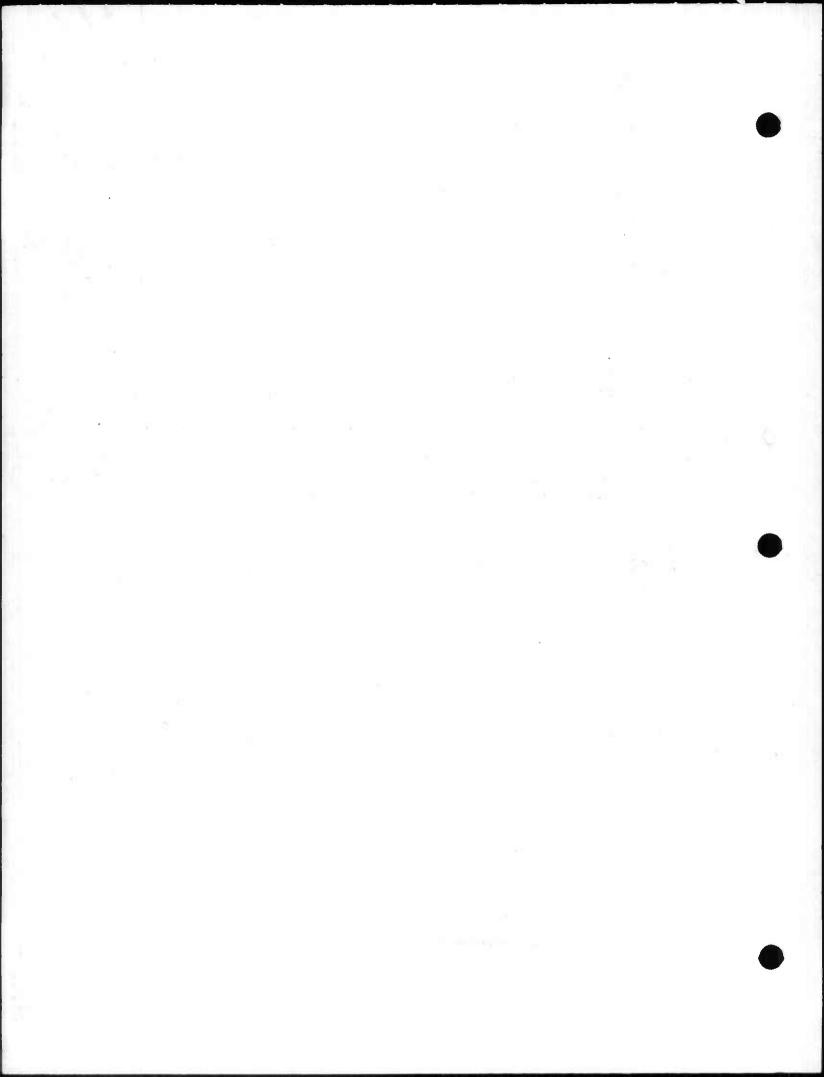
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

Beniamin Bishop 4 SORM SECURITY NUMBER 5 SEX 1212-09-6105 A 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
BENTALLY AMERICAN DISTRICT MANUEL (TO DESCRIPTIVE) 4. SOCIAL SECURITY MANUEL (TO DISTRICT MANUEL (TO DIST	tate or Foreign
THE STATE OF SAME (FOR Internal Section) (Page 1) Section	
212-09-6105 A	nd
3401 OakField Avenue Apt T-1 Baltimore	
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	2 NO
4 Homicide determined	Đ/,
29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manual ma	Θ',
29c. LICENSE NUMBER 29d. DATE SIGNED (Month,	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	ner se stated,
Liberty Medical Center 2600 Liberty Heights	ner se stated,
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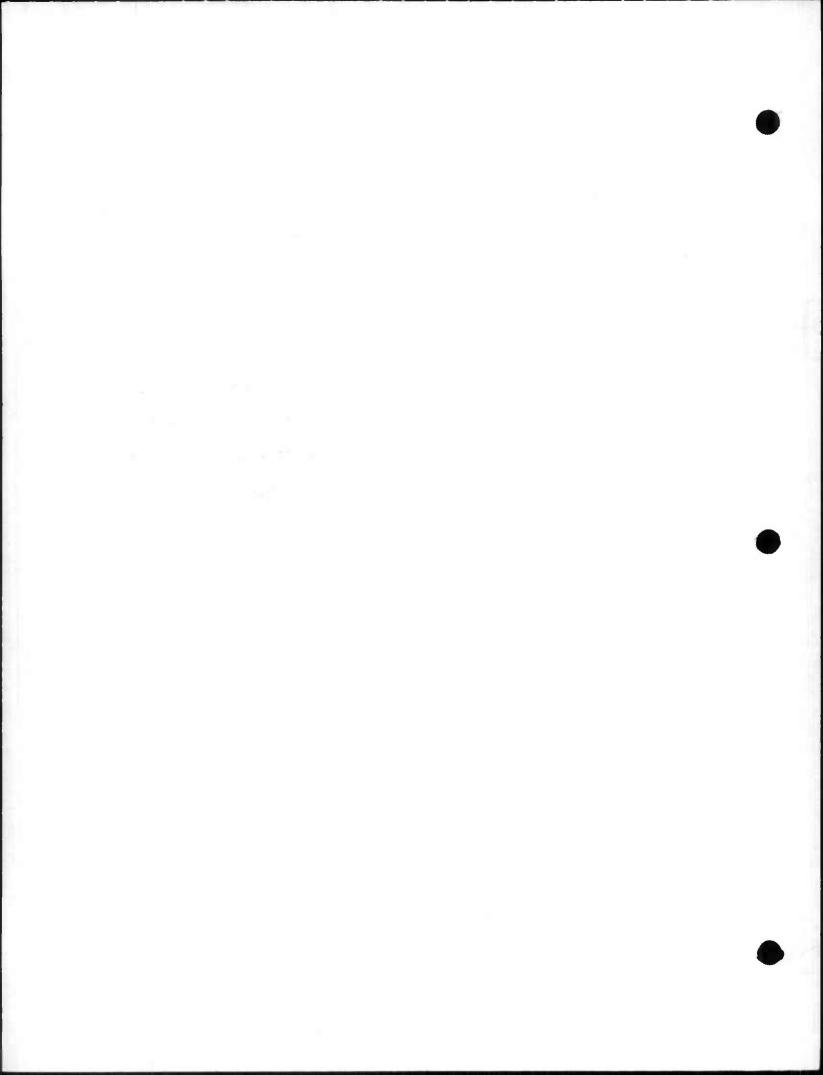
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DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH USE ary anca Sulla 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) BIRTHPLACE (State or Foreign JE UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 1 M 2 XF DAYS HOURS MIN. 216-05-0266 VRS April 6, 1912 Maryland permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number 9b. CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Northwest Hospital Randallstown Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Carroll County Sykesville 1 YES 2 NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit, burial, cremation, or removal. 6924 Stratford Drive 21784 U.S.A. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2X NO Specify: 14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Merried Specify: White BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementery/Secondary (0-12) College (1-4 or 5+) 3 Homemaker Domestic 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname 76 Giuseppe Isabella Serafina Cammarata BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. John J. Bianca 6924 Stratford Drive Sykesville, MD 21784 9 20a METHOD OF DISPOSITION
1 △ Burlel 2 □ Cremetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE must Cometery, crematory or other place)
Dulaney Valley Mem. Gard. 4 ☐ Donation 5 ☐ Other (Specify) _ 7/12/95 Timonium, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY death. HAIGHT FUNERAL HOME (P.O. Box 195) Alugar X Sykesville, MD 21784 (410)-795-1400 hours after medical 23. PART I. Enter the diseases, or complications that reused the death. Do not enter the mode of dying, such as cerdisc or respiratory strest, Approximate shock, or heart fallure. List only one ceuse on each line. interval Between IMMEDIATE CAUSE (Final Onset and Death the disesse or condition ngastive Part resulting in death) traumatic event, DUE TO JOR AS A CONSEQUENCE OF ace 12 Dines 6 CERTIFICATION and Sequentially list conditions, TO (OR AS A CONSEQUENCE OF): prior to the attending physician Mental Hygiene prior to if any, leading to immediate 2 cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 PART if. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY and t shows any Health a 1 YES 2 NO OF DEATH? 1 YES 2 NO t. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) tem certificate I HOSPITAL: OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specily) 0 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH this c marked, 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending M 1 YES 2 NO BY After 1 2 Accident Investigation ATTENDING 28e. PLACE OF INJURY — Al home, ferm, street, fectory, office building, etc. (Specify) 80 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED DIRECTOR: 4 Homicide 28 B 29e. CERTIFIER 1. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner se stated. TO THE HOSPITAL TO THE FUNERAL ED FILED WITHIN 72 h HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE 2 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ORTHWE 31. DATE FILED (Mon

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



DIVISION OF VITAL RECORDS, P.O. BOX 68760

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IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA		TMENT OF H		MENTAL HYGI		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATN
	Donna			Bender		July	- 1	999 11:40 PM
	SINC-ONCACO HISTORY		n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year	8	. BIRTNPLACE (State or Foreign Country)
	213-14-0584 9e. FACILITY NAME (If not institution, give street		76 YRS.			May 26,		Maryland
Œ	Frederick Memor		1	9b. CITY, TOWN C	Frederi			Y OF DEATH ederick
8	RESIDENCE OF DECEDENT	iai nospita	. 1		rrederi	CK	FL	edelick
DIRECTOR	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCAT	7.61			10d. INSIDE CITY LIMITS?
	Maryland Ca	rroll			t. Airy			1 TYES 2 NO
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	1 Never Merried 2 Married	FORCES? 1 YES	2 NO	If yes, spe	2 NO Specific	n, Puerto Rican, etc.)		Black, White, etc. Specify:
D BY	3 Widowed 4 Divorced							White
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade com	npleted)	(Give kind of v	VORK done during most	N st of working	16b. KIND OF	BUSINESS/INDUS	STRY
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)		one			None	
OM	17. FATHER'S NAME (First, Middle, Lest)		110	7110	18. MOTHER'S NA	ME (First, Middle, Mel		
BE C	Unknown	1				Unkr	nown	
2	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING			Route Number, City or	Town, State, Zip Co	ode)
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	4 Donalion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENS		bringin		D ADDRESS OF FA		resvii	ie, no
	Brian L.	Waidet.		HAIGH	T FUNERA	L HOME (
\dashv	23. PART I. Entar the diseases, or com	//	the death. Do n			MD 21784		
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	disease or condition resulting in daeth)	Right	lowe.	R 10	be D'	neumon	16	4 dones
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ATI	if any, leading to immediate cause. Enter UNDERLYING	DOL TO (ON AS A	CONSEQUENCE OF	.).				i l
E E	CAUSE (Diseese or injury thet initiated events	DUE TO (OR AS A	CONSEQUENCE OF	7):				
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							ZJE) NO	OF DEATH? 1 ☐ YES 2 ☐ NO
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF	DEATH YE	S NO E	UNCERTAIL	V 🗆		
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	6. PLACE OF DEAT	H (Check only one) OTHER:				
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BY	2 Accident Investigation 3 Suicide Could not be	26e. PLACE OF INJURY	- At home, farm, s			28I, LOCATION (Stre	et end Number or	Rural Route Number,
	4 Homicide 8 Could not be	building, etc. (Special	fy)			City or Town, St.	ato)	
COMPLETED	290. CERTIFIER (Check only	Y: To the beel of my knowle	edga, death occurre	d at the time, date	and piece, end due	lo the cause(a) and	manner ee atated.	
MO								cause(a) and manner ee stated.
BE C	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUM	IBER	29d. DATE S	NGNED (Month, Day, Year)
TO B	May Msn	2			D 269	516	J	Uly 5 1995
-	Aller T G. So	MPLETEO CAUSE OF OEA	TH (ITEM 27) (Type,	Print)	e	FLED N	10 Z	1702
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGNA	TURE			V		
	JUL 1 1 1995 Idia	Studior Rada	Us					

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

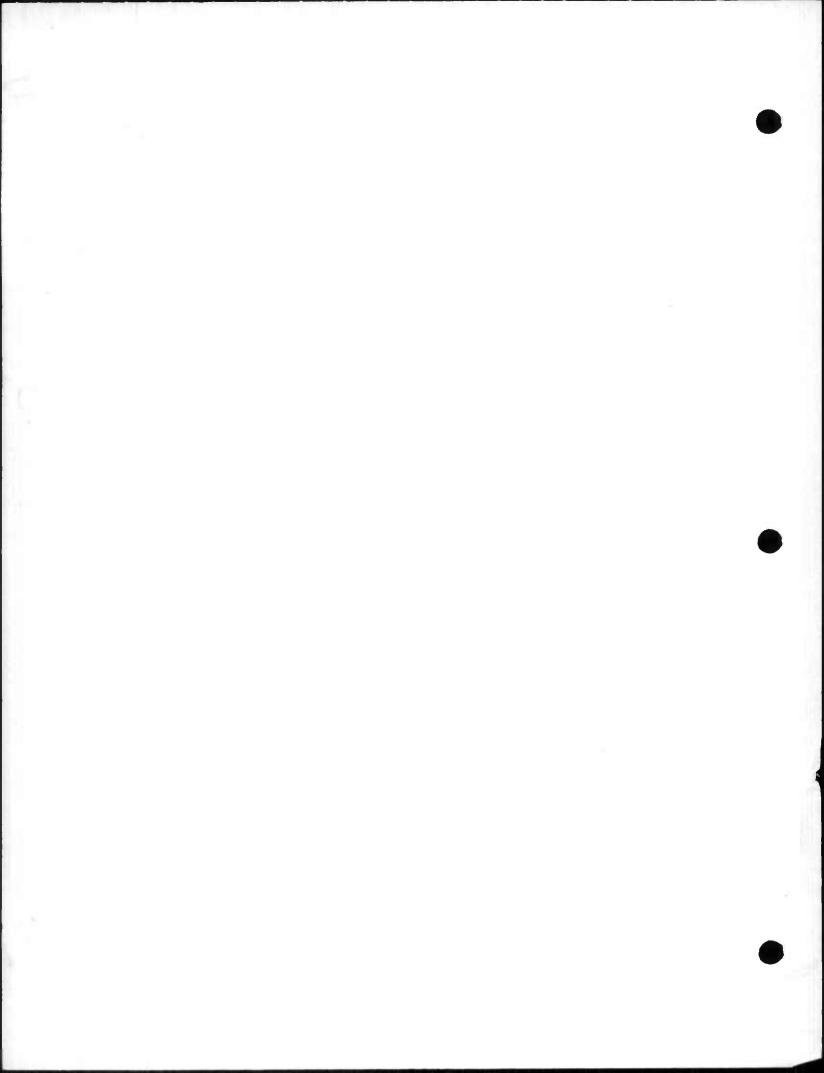
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

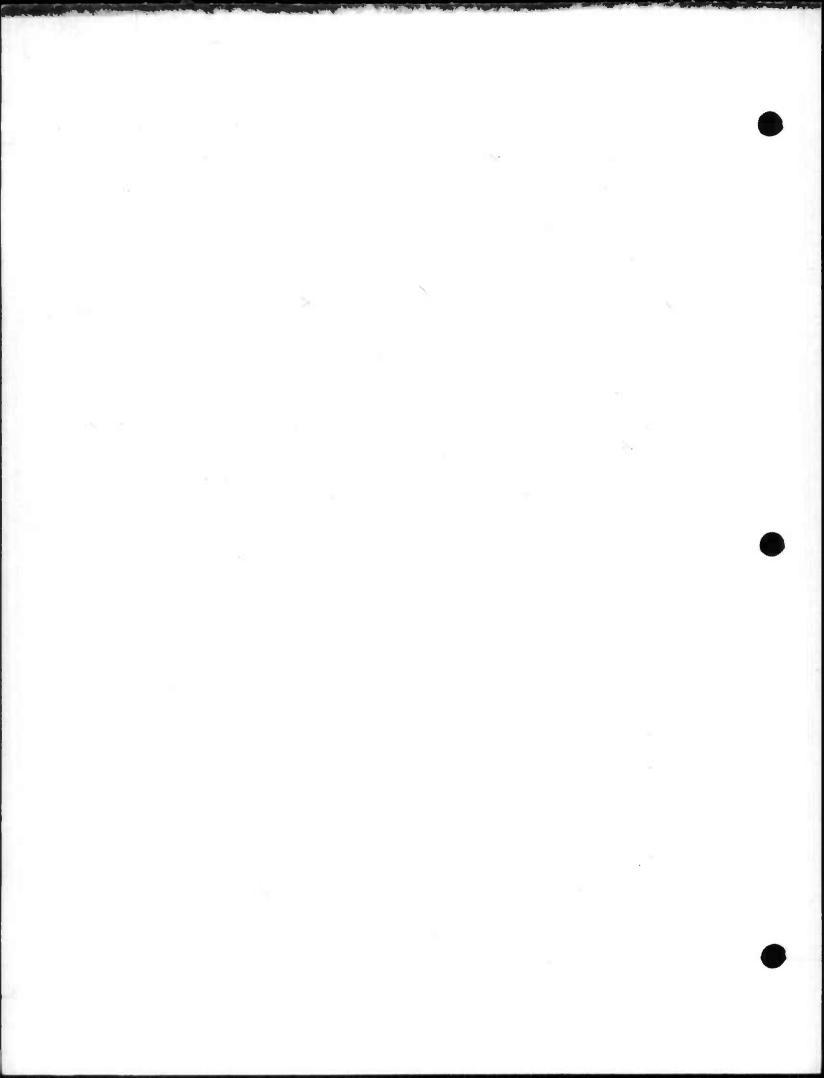
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTHAN		CERTIF	ICALE	JE DEATH	REG. NO).	
	1. DECEDENT'S NAME (First, Middle, Lest)					2. DATE OF DEATH		3. TIME OF DEATN
	VINCENT	C	CTCET	20	-		YEAR	00 500 4
		5. SEX 6. A	CICEF GE (In yrs. lest birthday)	IF UNDER 1 YE	AR IF UNDER 24 HRS.	JULY 10	and and and	08:50P M
	7.0 (1 M M 2 F	01	MONTHS DA		7. DATE OF BIRTN (Month, Day, Year)	6. BIFT	THPLACE (State or Foreign itry)
			SG YRS.			HARCH 13	1909 M	ARY/AND
	9a. FACILITY NAME (If not institution, give stre	et and number)		9b. CITY, TO	WN OR LOCATION OF		9c. COUNTY OF	DEATN
R	GREATER BALTIMORE	MEDICAL C	ENTER	TOWS	COM		DATET	ODE
Ĕ.	RESIDENCE OF DECEDENT			10112	7014		BALTIM	URE
DIRECTOR	10a. STATE 10b. COUNTY	-	10c. CIT	Y, TOWN OR L	OCATION			10d. INSIDE CITY
H	MUDY RIN B	hildren	***		10			LIMITS?
	10e, STREET AND NUMBER	AITIMO	Rel		0-14.			1 TES 2 NO
ZY	TOU. STREET AND NOMBER		1		101. ZIP CODE	4	10g. CITIZEN OF	WHAT COUNTRY?
<u> </u>	1009 HAI	YLCT	AUENU	2	21	234	11/-	5.A.
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVE		13. WAS	DECENDENT OF HISP	NIC ORIGIN? (Specify Ye	n or No.— 14. RA	CE — American Indian,
	1 Never Married 2 Married	FORCES? 1 Y		ony 11	, specify Cuban, Mexic	an, Puerto Rican, etc.)	Ble	ck, White, etc.
BY	3 🔀 Widowed 4 🗌 Divorced	ii izo, dive tani di	I DATES	,,,	YES 2 NO Spec	ny:	Spe	oly: Mhite
0	15. DECEDENT'S EDUCA	TION	16a, DECEDENT'S	HELIAL OCCU	MTION	T 401 1/1017 07 01	1	1011110
E	(Specify only highest grade or	impleted)		vork done during	most of working		SINESS/INDUSTRY	
ا ت	Elementary/Secondary (0-12)	College (1-4 or 5+)			0	Hr	ese R	200 010
불	14th	N.H.	SCLF 6	MP10.	red owne	K / C	THE K	4-CING
COMPLETE	17. FATNER'S NAME (First, Middle, Last)				16. MOTHER'S N	AME (First, Middle, Malder	Sumame)	
	VINCENT	5. ("	1CERO	SR	. MA	ev T.	30000	
BE	19a. INFORMANT'S NAME (Type/Print)			ADODECC (C)	and and Mumbers of Street	Boyte Number, City or Tox	JAU CH	10
2		Nes	100	ADDRESS (SIN	eet and Number of Hura	1.1 1	vn, State, Zip Code)	11 0
	11/0.	1063	182	1/ho	ENTON 1	1dge RA	10ws0	N. M. 21204
	20a, METNOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remov		20b. PLACE AND DATE		N (Name of	OATE 20c. LC	CATION - City or 1	own, Stata
	4 Donation 5 Other (Specify)	an from State	cemetary, crematory or of	her place)	RAL Cer	17-14 R	AltINO	a. Mercel. "
	21. SIGNATURE OF FORERAL SERVICE LICE!	NSEE			E ANO ADDRESS OF F	KO ITY	KI I I I I I	a Mary HUI
- 1	. /////	1					T	
- 1	10 pare	-a	neon	263	Con	rainino o	r. Fund	eral Home
	23. PART I. Enter the diseases, or con	molication's that cau	sed the death. Do n			trind 26.	Balto	Md 21224
	ahock, or heart fallure Lis	st only one cause or	n each lina.	ot ental the	moda or dying, ao	an wa cardiac or resp	iratory arrast,	Approximate Interval Between
	IMMEDIATE CAUSE (Fine)	/						Onset and Death
- 1	disease or condition resulting in death)	CONGI	ESTIVE	= HO	EART	FAILU	RE	
- 1		DUE TO (OR A	E A COMOCOURNES OF					
- 1		CADA	NBOW	A	RTER	y D15	EASE	
CERTIFICATION	Sequentielly list conditions, b.	OUE TO (OR A	S A CONSEQUENCE OF	- /	11/6/	1000	-176	
F	if any, leading to immediate cause. Enter UNDERLYING	702 10 (011 /	S A GONISEOULINGE OF	<i>)</i> -				i I
2	CAUSE (Diseese or injury C.							
<u> </u>	that initiated events	DUE TO (OR A	S A CONSEQUENCE OF):				
E	reaulting in death) LAST							
- 11	DART II ONL II- III							
EDICAL	PART II. Other aignificent conditions		-	n the underl	ying ceuse given in	Part i. 24a. WAS AN		. WERE AUTOPSY FINDINGS
일	PULMOINA	RYEI	4B021	SM.				AMAILABLE PRIOR TO COMPLETION OF CAUSE
유미						1 _ YES 2	SINO	OF DEATH?
Σ						- un	1	1 - YES 2 - NO
4 0	DID TOBACCO USE CONTRI	BUTE TO CAUSE	OF DEATH YE	S NO	☐ UNCERTAI	N 🔯		
z I			26. PLACE OF DEAT	H (Check only o	nne)			
AN	25. WAS CASE REFERRED TO MEDICAL			OTHER:		Value and		
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	introffeet 3 - DOA					
IYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 200 NO	Vinpatient 2 ☐ ER/O		4 - Nursing I	Nome 5 Residence			
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1		TY 28b. TIME	4 Nursing I OF 28c.	Nome 5 Residence INJURY AT WORK?	28d. OESCRIBE HOW I	NJURY OCCURED	
BY PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 200 NO	Inpetiant 2 ER/O	Y 28b. TIME	4 Nursing I OF 28c.	INJURY AT		NJURY OCCURED	
à l	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	28a. OATE OF INJUR (Month, Day, Yea	r) 28b. TIME INJU	4 Nursing I OF 28c. JRY 1	INJURY AT WORK? YES 2 NO	28d. OESCRIBE HOW I	and Number or Rural	Route Number,
à l	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation	Vinpetlant 2 ER/O 28a. OATE OF INJUR (Month, Day, Yea	r) 28b. TIME INJU	4 Nursing I OF 28c. JRY 1	INJURY AT WORK? YES 2 NO	28d. OESCRIBE HOW I	and Number or Rural	Route Number,
à l	25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 YES 2 NO 1. ANANNER OF DEATH 1 Avatural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined	Anpetiant 2 ER/O 28a. OATE OF INJUR (Month, Day, Yea 28a. PLACE OF INJU building, etc. (S	IY 28b. TIME INJU	4 Nursing I OF 28c. JRY M 1 [treet, factory, c	INJURY AT WORK? YES 2 NO	28f. LOCATION (Street City or Town, State)	and Number or Rural	Route Number,
à l	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be datermined 29e. CERTIFIER (Check only)	Inpetiant 2 ER/O 28a. OATE OF INJUR (Month, Day, Yea 28e. PLACE OF INJUR building, etc. (S) AN: To the best of my kn	PY 28b. TIME INJURY — At home, farm, a poetly)	4 Nursing I OF 28c. JRY M 1 Irreet, factory, c	INJURY AT WORK? YES 2 NO Wifice	28d. OESCRIBE HOW I 28f. LOCATION (Street City or Town, State)	and Number or Rural	
à l	25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 YES 2 NO 1. ANANNER OF DEATH 1 Avatural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined	Inpetiant 2 ER/O 28a. OATE OF INJUR (Month, Day, Yea 28e. PLACE OF INJUR building, etc. (S) AN: To the best of my kn	PY 28b. TIME INJURY — At home, farm, a poetly)	4 Nursing I OF 28c. JRY M 1 Irreet, factory, c	INJURY AT WORK? YES 2 NO Wifice	28d. OESCRIBE HOW I 28f. LOCATION (Street City or Town, State)	and Number or Rural	
COMPLETED BY	25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA CONE) 2 MEDICAL EXAMINER:	Inpetiant 2 ER/O 28a. OATE OF INJUR (Month, Day, Yea 28e. PLACE OF INJUR building, etc. (S) AN: To the best of my kn	PY 28b. TIME INJURY — At home, farm, a poetly)	4 Nursing I OF 28c. JRY M 1 Irreet, factory, c	INJURY AT WORK? YES 2 NO Writice date and place, and duen, death occured at the	28d. OESCRIBE HOW I 28f. LOCATION (Street City or Town, State) to the cause(s) and man time, date and place, en	and Number or Rural ner as atsted, id dua to the cause(a) and manner sa stated.
E COMPLETED BY	25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA One) 2 MEDICAL EXAMINER:	28a. OATE OF INJUR (Month, Day, Yea 28a. PLACE OF INJUR building, etc. (S AN: To the best of my kn On the basis of examins	PY 28b. TIME INJUSTICE OF TIME	4 Nursing I OF 28c. HY M 1 Ireet, factory, c d at the time, c	INJURY AT WORK? YES 2 NO Intitice	28d. OESCRIBE HOW I 28f. LOCATION (Street City or Your, State) to the cause(s) and man time, date and place, an	and Number or Rural Iner as stated, d dus to the cause(s) and manner as stated.
BE COMPLETED BY	25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER	28a. OATE OF INJUR (Month, Day, Yea 28a. PLACE OF INJUR building, etc. (S AN: To the best of my kn On the basis of examins	PY 28b. TIME INJUSTICE OF TIME	4 Nursing I OF 28c. HY M 1 Ireet, factory, c d at the time, c	INJURY AT WORK? YES 2 NO Intitice	28d. OESCRIBE HOW I 28f. LOCATION (Street City or Your, State) to the cause(s) and man time, date and place, an	and Number or Rural Iner as stated, d dus to the cause(s) and manner as stated.
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BE COMPLETED BY	25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER	28a. OATE OF INJUR (Month, Day, Yea 28a. PLACE OF INJU- building, etc. (S	PY 28b. TIME INJUSTICE OF TIME	4 Nursing I OF 28c. HY M 1 Ireet, factory, c d at the time, c	INJURY AT WORK? YES 2 NO Intitice	28d. OESCRIBE HOW I 28f. LOCATION (Street City or Your, State) to the cause(s) and man time, date and place, an	and Number or Rural Iner as stated, d dus to the cause(s) and manner as stated.
TO BE COMPLETED BY PHYSICIAN	25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER A. H. S. H. L. A. 30. NAME AND ADDRESS OF PERSON WHO CO.	AN: To the best of examina To the best of examina COMPLETED CAUSE OF	Pry 28b. TIME INJUSTICE At home, farm, signedly) Owledge, death occurrention end/or investigation OEATN (ITEM 27) (Type,	4 Nursing I OF 28c. HY M 1 Ireet, factory, c d at the time, c	INJURY AT WORK? YES 2 NO Intitice	28d. OESCRIBE HOW I 28f. LOCATION (Street City or Your, State) to the cause(s) and man time, date and place, an	and Number or Rural Iner as stated, d dus to the cause(a) and manner sa stated.
BE COMPLETED BY	25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER	28a. OATE OF INJUR (Month, Day, Yea 28a. PLACE OF INJU- building, etc. (S	Pry 28b. TIME INJUSTICE At home, farm, signedly) Owledge, death occurrention end/or investigation OEATN (ITEM 27) (Type,	4 Nursing I OF 28c. HY M 1 Ireet, factory, c d at the time, c	INJURY AT WORK? YES 2 NO Intitice	28d. OESCRIBE HOW I 28f. LOCATION (Street City or Your, State) to the cause(s) and man time, date and place, an	and Number or Rural Iner as stated, d dus to the cause(s) and manner as stated.



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	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	TMENT (OF HEALTH AI	ND ME	NTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					2.	DATE OF DEATH			3. TIME OF DEATH
	ANNA Z. CONN	1OR						-1	995	2:150H
1	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 Y			DATE OF BIRTH (Month, Day, Year)			IPLACE (State or Foreign
	212-01-2357	1 🗆 M 2 💢 F	79 YRS.	MONTHS	AYS HOURS &	an. 1	2-20-19	915	MAI	RYLAND .
_ 1	9a. FACILITY NAME (If not institution, give s	treet and number)		9b. CITY, TO	OWN OR LOCATION	OF DEATH		9c. COUR	NTY OF D	
5	CHARLESTOWN			N/A				BAL	TIMO	DRE
EC	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	Y	10c, CIT	Y, TOWN OR	LOCATION					10d. INSIDE CITY
DIRECTOR	MARYLAND BALT	TIMORE		N/A						LIMITS?
	10e. STREET AND NUMBER				10f. ZIP CODE			10g. CiTi	ZEN OF V	VHAT COUNTRY?
ER	717 MAIDEN CHO	ICE LANE			21228	3		U.	.S.A	١.
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER II FORCES? 1 YES	U.S. ARMED				PRIGIN? (Specify Yes	or No-	14. RACE	American Indian,
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES		PS 2 NO	fexican, Pr Specify:	uerto Rican, etc.)	- 1	Speci	y:
	15. DECEDENT'S EDUC	0471011					<u> </u>			WHITE
H	(Specify only highest grade	completed)	18a. DECEDENT'S (Give kind of v life. Do NOT us	work done duri	JPATION ng most of working		16b. KIND OF BUS	SINESS/IND	USTRY	
2	Elementary/Secondary (0-12)	College (1-4 or 8+)	HOUSEV				HOMEN		,	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		посоди	VILL	18. MOTHER	'S NAME (First, Middle, Meiden		Χ	
ш	AUGUST ZIMMER	MAN			D-10 - 10 - 10 - 10 - 10 - 10 - 10 - 10		INA DOF			
9	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (S			Number, City or Town		Code)	
2	SUSAN L. FLYNN	<u> </u>	23 F	KINGS	BRIDGE	E RD	· ST. J	OHNS	S NE	WFOUNDLAN
	20a. METHOD OF DISPOSITION 1 ☐ Burlal 2 ★ Cremation 3 ☐ Reme	gvel from State	PLACEANDDATE	OF DISPOSITIO	ON /Name of	diam'r.	DATE 20c. LO	CATION —		
	4 Donation 5 Other (Specify)		ÄRKWOOI	V				RKVI	LLE	,MD.
	21. SIGNATURE OF FUNERAL SERVICE LIC		_		ENRY W		nkins &	SON	IS C	'0
	Willem K.	Paris	٠				D. BALT			
	23. PART I. Enter the diseases, or of shock, or heart failure.	complications that caused List only one cause on a	the desth. Do r	ot antar th	a moda of dying,	such as	cardiac or reapi	ratory arr	eat,	Approximate Interval Batween
	IMMEDIATE CAUSE (Final	ARTERIO		TicC	ARdiox	ASCI	UnR]	SE	ASE	Onest and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	F):						
CA	ceuse. Enter UNDERLYING CAUSE (Disease or Injury	C								
E	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	F):						
Ä	Tourising in death) Exist	u								
4	PART II. Other aignificant condition	s contributing to deeth b	ut not resulting i	in the unda	rlying cause give	n in Pari	24e. WAS AN PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDIC								,		1 TYES 2 NO
ä	DID TOBACCO USE CONTR					TAIN A	ZÍ			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	H (Check only	one)					
ΥS	1 YES 2 NO 27. MANNED OF DEATH	1 Inpetient 2 ER/Outp		4 Nursing	Home 5 - Raside					
	1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIMI	URY	WORK?		1. DESCRIBE HOW II	NJURY OCC	URED	
ВУ	2 Accident Investigation 3 Suicide & Could get be	28a. PLACE OF INJURY	— At home form a		YES 2 No		LOCATION (Street a		. 0 . 10	
COMPLETED	4 Homicia 6 Could not be	building, etc. (Spec	elfy)	ereet, nactory,	onice	201	City or Town, State)	ind Number	or Hurai H	oute Number,
Ä	29 CENTIFIER 1 CERTIFIED PHYSIC	CIAN: To the best of my knowl	adea death necum	of at the store	deta and above an	4 4 - 4 - 11		285	5-2	
MA .		R: On the beals of examination								and manner as stated.
Š	MINISTER AND THE OF CERTIFIER				29c. LICENSE					(Month, Day, Year)
M	1 100 Ot 15	In Act	11_ m	1)	D11	171		▶7	-LD	-95
M	MAME AND ADDRESS OF PERSON WHO					PI		<i>K</i>	-	/
		SON M.D. 4	05 FRED	ERIC	K AVE.	CAT	ONSVILL	E,MD	. 2	1228.
	11. DATE FILED (Month, Day, Year)	12. NEGISTRAN'S SUR	ATUNE			-				
_1	JUL 1 1 1995	War to the same sa	- 1-10-9							



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BOX	
P.0.	
RDS,	
RECORDS,	
TAL B	
OF VITAL	
DIVISION	

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 26 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	Item1 7-11-95 Fi	1mG725 W.H.Per F/H		95	20830
	1 - FOR STATE REGISTRAR	TE OF MARYLAND / DEPARTM CERTIFICA	ENT OF HEALTH AND	MENTAL HYGIENE REG. NO.	
DR	1. DECEDENT'S NAME (First, Middle, Last) ROBERT CROSSY 4. SOCIAL SECURITY NUMBER 5. SEX	Robert Emmanuel Cr. 9. AGE (In yrs. lest birthday) Ft. YRS. MON	OS by	2. DATE OF DEATN DAY JULY 6, 1995 7. DATE OF BHRTN (Month, Day, Year) The 1 96. COUNTY	3. TIME OF DEATH 5:27 P M BIRTHPLACE (State or Foreign Country) OF, DEATH
FUNERAL DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10e. STREET AND NUMBER 2 0 40 CSC L 11. MARITAL STATUS 1 Never Merried 1 Merried 1 Population Status		WN OR LOCATION LYNOYE 101. ZIP CODE 212	INIC ORIGIN? (Specify Yes or No	10d. INSIDE CITY LIMITS? 1 YES 2 NO ROF WHAT COUNTRY? RACE — American Indian, Black, Writa, etc.
COMPLETED BY	(Specify only highest grade completed Elementary/Secondary (0-12) To FATHER'S NAME (First, Middle, Last)	16a, DECEDENT'S USU	AL OCCUPATION fone during most of working red.) EEDGY	16b. KIND OF BUSINESS/INDUS' MCDICAL TO AME (First, Middle, Maiden Surname)	Black
TO BE	19a. INFORMANT'S NAME (Type/Print) 20a. METHOD OF DISPOSITION 10 Burlel 2 Cremation 3 Removal from 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSE	19b. MAJLING ADD OSA 20b. PLACE AND DATE OF DIS comparely, cremency or other p	SPOSITION (Name of lace) Of Marketery 22. NAME AND ADDRESS OF FI	7/13/95Baltin	tinove Ned or Town, State LUVE, PLANY LOHA TERSTOWN ROAD SOLUTE NELL HOLE
	23. PART I. Enter the diseases, or complice shock, or heart failure. List only IMMEDIATE CAUSE (Final disease or condition resulting in death)	orions that coused the deeth. DD not element on each line. TRACRANIAL HEMORE DUE TO (OR AS A CONSEQUENCE OF):		h es cerdiec or reapiratory arrest	Approximate interval Between Onset and Death
CERTIFICATION	Sequentially list conditions,	DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):		IT IS	3 DAYS
PHYSICIAN: MEDICAL	PART II. Other aignificant conditions contrib	buting to death but not resulting in th	e underlying couse given in	Part i. 24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
ICIAN: N	DID TOBACCO USE CONTRIBUTE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 (5) YES 2 NO 1 (A) India	26. PLACE OF DEATH (CA	HER:		
ED BY	27. MANNER OF DEATN 28e 1 Netural 5 Pending 2 Accident Investigation	atlent 2 ER/Outpetient 3 DOA 4 DOA B. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY INJURY 28b. TIME OF INJURY At home, term, street, building, etc. (Specify)	Nursing Home 5 Residence 28c. INJURY AT WORK? M 1 YES 2 NO factory, office	Other (Specify) 28d. DESCRIBE HOW INJURY OCCUR! 28t. LOCATION (Street and Number or Filtry or Town, State)	
COMPLET	one) 2 MEDICAL EXAMINER: On the	the best of my knowledge, death occurred at basis of examination and/or investigation, in	my opinion, death occured at the	time, data and place, and dua to the ca	
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COMPA	lain 7. Llogd	29c. LICENSE NU	MBER 29d. DATE SIG	GNED (Month, Day, Year) VLY 6, 1995

29d. DATE SIGNED (Month, Day, Year)

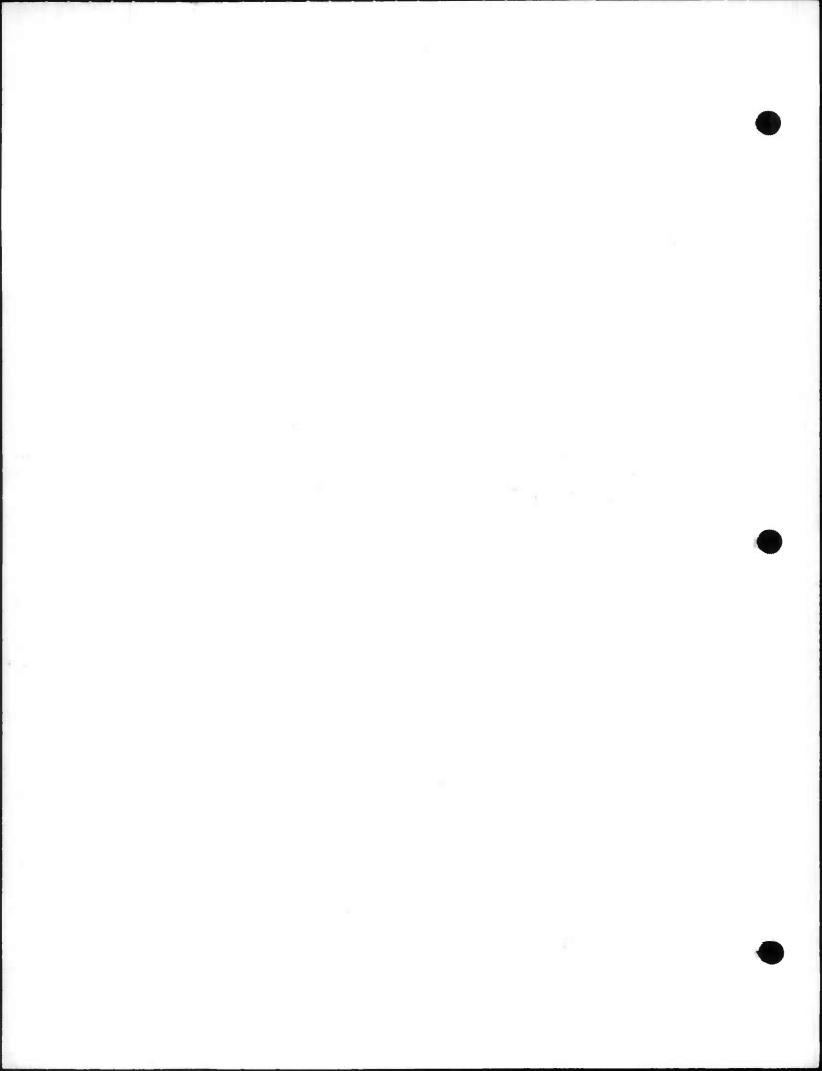
JULY 6, 1995 acon 7. J874 X 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) BLAL JOHNS HOPKINS HOSPITAL, BALTIMORE, MD

32 REGISTRAR'S SIGNATURE

31. DATE FILED (Month, Day, Year)

JUL 11 1995

AARON



21215-0020
MARYLAND
BALTIMORE,
BOX 68760
S, P.O. B

DIVISION OF VITAL RECORD

THE MOSPITAL OR ATTENDING PHYSICIÁN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: It item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSICI	TO THE FUNERAL DIRECTOR: After this cer be filed within 72 hours after death with th	IMPORTANT: It item 28 is marked, o	

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	ERTIFIC	ATE OF DEATH	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH		3. TIME OF DEATH	
	DOROTHY MARIE CLARK	_		MONTH D		130 D.	
· '	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. In				1995	7 P M	
9	The state of the s		UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	Coun	NPLACE (State or Foreign try)	
	051-26-9653 10M2 XF 63	YRS.	The state of the s	APRIL 21,1	932 NE		
	9a. FACILITY NAME (If not institution, give street and number)	96	CITY, TOWN OR LOCATION OF D		9c. COUNTY OF		
Œ	10551 GATERIDGE Road	ļ	Convenience	ce.			
10551 GATERIOGE ROAD COCKEYSVILLE BALTIM							
10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE							
FUNERAL	10e. STREET AND NUMBER		101. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?	
8	10551 GATERIDGE Rd		21093		US	Δ	
Ξ	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. A	DIAFO				,	
교	1 Never Married 2 Married FORCES? 1 YES 2	NO	13. WAS DECENDENT OF HISPAI If yes, specify Cuben, Mexico	NIC ORIGIN? (Specify Yes an, Puarto Rican, etc.)	or No- 14. RAC	E — American Indian, ck, White, atc.	
B	3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES		1 TYES 2 NO Specif		Spec	offy:	
					I W	TITE	
Ш	15. DECEDENT'S EDUCATION (Specify only highest grade completed) (6	ECEDENT'S USL	AL OCCUPATION	166. KIND OF BUS	SINESS/INDUSTRY		
	Elementary/Secondary (0-12) College (1-4 or 5+)	e. Do NOT use re	done during most of working lired.)				
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2		10001				Coulibrain	
COMPLETED	17. FATNER'S NAME (First, Middle, Last)			AME (First, Middle, Maiden			
H	LUCHN KAY		KIT.	TY DOYL	E		
	19a. INFORMANT'S NAME (Type/Print)	9b. MAILING ADI	DRESS (Street and Number or Rural				
2							
- 1	JOHN J. Clarke	10221	Gateridge 1				
	20a, METHOD OF DISPOSITION 1	ANDDATEOFD	SPOSITION (Nema of		CATION — City or T		
	4 Donation 5 Other (Specify)	R BAP1	FIST CHURCH CEM	7/12/95 Lu	ruco ulla	Md	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FA	CUTY	HERVINE	1.10.	
	ton and of		EVANS CHAPES				
	harles of Cities H.		2325 York F	d Timoni	LM	21003	
	23. PART i. Enter the diseases, or complications that caused the di	eath De set	Table the most of delay	id Timoni	UM INIO		
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	allow, or most issues, that only one cause on each line	· ·				Interval Retween	
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	immediate cause (Fine) disease or condition resulting in death) a. Myocara 12	Infa.	retion				
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BE COMPLETED BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Finel disease or condition reculting in death) a. DUE TO (OR AS A CONSE DUE TO (OR AS A CONSE DUE TO (OR AS A CONSE CAUSE. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH TI. Other significent conditions contributing to death but not Tobacco Aouse DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH CAUSE OF DEATH TO TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH TO TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH TO TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH TO TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH TO TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH TO TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH TO TOBACCO USE CONTRIBUTE TO CAUSE OF INJURY — At he building, etc. (Specify) One) 2 MEDICAL EXAMINER: On the beat of my knowledge, displayed to the deatermined To the beat of my knowledge, displayed to the deatermined To the beat of axamination and/or Spb. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITER TO TO THE DEATH (ITER TO TO THE DEATH (ITER TO TO THE DEATH (ITER TO TO THE DEATH (ITER TO TO THE DEATH (ITER TO TO THE DEATH (ITER TO T	EQUENCE OF): EQUENCE OF): EQUENCE OF): Treaulting in the control of the contro	NO UNCERTAIL heck only one) HER: Nursing Home 5 Residence 28c. INJURY AT WORK? M 1 YES 2 NO t, factory, office the time, date and place, and due my opinion, death occured at the	8 Other (Specify) 28d. DESCRIBE NOW II 28f. LOCATION (Street a City or Town, State) to the cause(a) and man time, data and place, and	NURY OCCURED and Number or Rural ner as stated. d due to the cause(29d. DATE SIGNED	Onset and Death Do. WERE AUTOPSY FINDINGS ANAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, a) and menner as stated. O (Month, Day, Year) 1 1995	
BE COMPLETED BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Finel disease or condition reculting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DIE TO (OR AS A CONSE DUE TO (OR AS A CONSE	EQUENCE OF): EQUENCE OF): EQUENCE OF): Treaulting in the control of the contro	NO UNCERTAIL theck only one) HER: Nursing Home 5 Residence 28c. INJURY AT WORK? 1 YES 2 NO t, factory, office the time, date and place, and due my opinion, death occured at the	8 Other (Specify) 28d. DESCRIBE NOW II 28f. LOCATION (Street a City or Town, State) to the cause(a) and man time, data and place, and	NURY OCCURED and Number or Rural ner as stated. d due to the cause(29d. DATE SIGNED	Onset and Death Do. WERE AUTOPSY FINDINGS ANAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, a) and menner as stated. O (Month, Day, Year) 1 1995	

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	3 should	
	2	
	ages 1	
PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physician.	the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trangit permit. Pages 1, 2, 3 should	
feath, P.	funeral	
rs after o	by the	- mondo
DOU	lled in	200
•	ly fil	neign
within be	s certificate has been signed by the attending physician and completely filled in by the	I Acces
execut	and c	be besein
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OR AT	DIRECT	o warner
PITAL	RAL	1 mm
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TO THE	THE CL	ha 6tad

IMPORTANT. If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	Item4,Film725	,7/11/9	95,1t									95	2 (0832
	FOR STATE REGISTRAR		STATE OF N		DEPAR					MENTA	L HYGIEN	E		
	1. DECEDENT'S NAME (First, A	Aiddle, Last)	EI			(0	AT	4.		2 DATE	of DEATH	199	YEAR 3.	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		5. SEX 1 M 2 F	6. AGE (In yrs. les	t birthday) YRS.	IF UNDE	DAYS	IF UNDER	24 HRS. MIN.	7. DATE (Monti	OF BIRTH 1, Day, Year) 9, 18	99	8. BIRTHPL Country) Mary	and
OR	90. FACILITY NAME (II not inst Belair Conva	lescen	et end number) t Center				lair	R LOCATIO	ON OF DE	ATH		1	rford	
DIRECTOR	Maryland	10b. COUNTY			10c cit	I EIM	OR LOCAT	ION						d. INSIDE CITY LIMITS? YES 2 NO
FUNERAL	100. STREET AND NUMBER 3409 Lake Mo	ntebel	lo Drive	9			101	ZIP CODI	218			10g. CITIZ Un	EN OF WHA	T COUNTRY? States
BY	11. MARITAL STATUS 1 Never Merried 2 N 3 Widowed 4 Divorce	lerried	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 241	RMED	13.	If yes, spe	ENDENT O	n, Mexica	n, Puerto I	I? (Specify Yes Ricen, etc.)	or No—	14. RACE — Black, V Specify:	American Indian, white, etc. White
COMPLETED		DENT'S EDUCA highest grade co) (G	CEDENT'S live kind of a Do NOT us SECTE	work done se retired.)	during mo	ON st of workin	ng	16b	KIND OF BUS		ustry ng Con	npany
BE CON	17. FATHER'S NAME (First, Midd Calvin	dle, Last) Benj	amin	Cooper				18. MOTH Fra	HER'S NAI	ME (First, I	diddle, Maiden Iverta	Surname)	Sc	chultz
TO B	189. INFORMANT'S NAME (TANK) Mr. Marion F	· Coop	er	19	P 9 WILLING	ADDRES Bene	sch •	Circ	ľe ^{vol f}	829	ow, City or Town Glen B	n, State, <i>Zip</i> Burnie	Code) MD	21060
	20c. METHOD OF DISPOSITION 1/2/ Burlel 2 Cremetton 3 Removal from State 4 Donetton 5 Other (Specify) 20c. LOCATION - City or Town, State Municipal Company													
	21. SIGNATURE OF FUNERAL Valerie	1. Boto	huch blyniak			Mc 32	Cui 04 M	ly F	uner ain	aT H Road	ome of Pasad	Pasa lena,	adena MD.	21122
	23. PART I. Enter the dis- shock, or hee IMMEDIATE CAUSE (Final disease or condition resulting in death)	ert Isliure. Li	MU	ceused the dese on sech line	FAR	CT				ENT		ratory arre	eat,	Approximate interval Between Onset and Desth
ERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING													
	CAUSE (Disease or injury that initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):													
PHYSICIAN: MEDICAL C	SEIZURE DISORDER PERFORMED?							RE AUTOPSY FINDINGS ALLABLE PRIOR TO MMPLETION OF CAUSE DEATH?						
N.	DID TOBACCO US									_			'	YES 2 NO
SICIA	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO	1	HOSPITAL:		E OF DEAT	ОТНЕ	R:	- 5						
	27. MANNER OF DEATH 1 Natural 5 Pe		28e. DATE OF (Month, Da	INJURY	28b. TIM	_	28c. INJU WOI	JRY AT			B Cother (Specify) 28d. DESCRIBE HOW INJURY OCCURED			
TED BY	3 Suicide 8 Co	ould not be termined	28e. PLACE Of building,	FINJURY — At ho etc. (Specify)	me, ferm, s	street, fac	tory, office)			OCATION (Street and Number or Rural Route Number, Zity or Town, State)			e Number,
COMPLET			AN: To the best of On the bests of ex											nd menner as stated.
BE	296. SIGNATURE AND TITLE O		wool	i my	2				NSE NUM	BER 57	6	29d. DATE	SIGNED (M	onth, Day, Yeer)
2	30. NAME AND ADDRESS OF P	PERSON WHO	COMPLETED CAUS	E OF DEATH ATE	H 27) (Trop	Defeat		-	_					



30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

ANDROW NEWA ROUGE!, MD

T' 1995

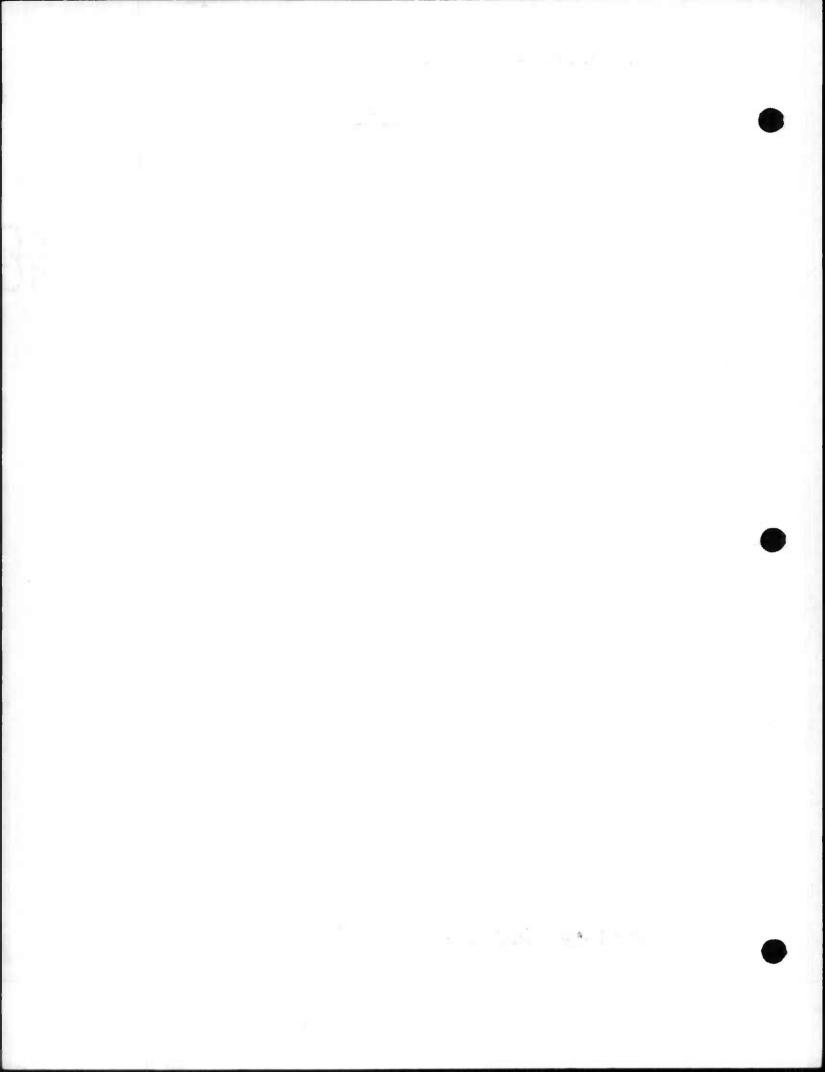
32. REGISTRAR'S SIGNATURED

125 N. MAINST, BER ARR, MO 2101

DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	CATE OF	DEATH	REG. N	10.		
1	1. DECEDENT'S NAME (First, Middle, Last)	CHMIELEWSKI			2. DATE OF DEATH			3. TIME OF DEATH	
	IRENE A	NNE	CHA	HELEN.	SKI	JUL4	10 /4	995	2:45 44
			E (in yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		- B	PLACE (State or Foreign
	112 03 70		30 YRS.	MONTHS DAYS	HOURS MIN.	Sept 3		Country)	SYLVANIA
~	9a. FACILITY NAME (If not institution, give street			9b. CITY, TOWN	DR LOCATION OF DI			TY OF DE	ATH
DIRECTOR	GOOD SAMARITAN	HOSPITAL	-	BAL	TIMORE			-	
EC	10a. STATE 10b. COUNTY		10c. CITY	, TOWN OR LOCA	TION	-			10d. INSIDE CITY
	Md. BAL	TIMORE	1	PARKVIL	LE				LIMITS?
AL	10e. STREET AND NUMBER				f. ZIP CODE		10g. CITIZ	EN OF W	AT COUNTRY?
FUNERAL	8309 NUNLEY		APT F		2123	+	l	USA	1
교	11. MARITAL STATUS 1 Never Married 2 Married	2. WAS DECEDENT EVER FORCES? 1 YE	R IN U.S. ARMED	13. WAS DE	CENDENT OF HISPAN	NIC ORIGIN? (Specify 'n, Puarto Rican, etc.)	Yes or No- 1	14. RACE - Bleck.	- American Indian, White, atc.
BY	3 N Widowed 4 Divorced	IF YES, GIVE WAR OR			2 NO Specif			Specify	
ED	15. DECEDENT'S EDUCAT (Specify only highest grade col	(ION	16a. DECEDENT'S	USUAL OCCUPATI	ON	16b. KIND OF E	BUSINESS/INDU		III E
		College (1-4 or 5+)	life. Do NOT use	rork done during me e retired.)	ost of working	.,			
COMPLETED	10		House	ewife		Hon			
	17. FATHER'S NAME (First, Middle, Last) ANDREW PAVI	1000011				ME (First, Middle, Maid			
BE	19a. INFORMANT'S NAME (Type/Print)	LISCSAK	195 MAILING	ADDRESS (Street	JULII	A KOB Route Number, City or 1			
2	0	ENGER	830		LEY DE	2 APT F			21234
	20a. METHOD OF DISPOSITION 1 & Burlal 2 Cremation 3 Remove	2	0b. PLACE AND DATE O	EDISPOSITION IN	ame of	DATE 200 I	OCATION C	the or Town	n Photo
	4 Donation 5 Other (Specify)		emetery, cremetory or oth HOLY Rec	leemer (Cemeter	2 7/13/95 B	ALTIMO	DRE	Md.
	21. SIGNATUME OF FUNERAL SERVICE LICEN	O Case		22. NAME A	NO ADDRESS OF FA	of Memo			
	Medent W	Troves		8800	5 CHAPEL D HAREC	ORD Rd.	Balto	.Md	1.21234
	23. PART i. Enter the diseases, or con shock, or heart failure. Lis	npilcations that cous	ed the death. Do n	ot enter the mo	de of dying, suc	h ea cerdiac or res	piratory erre	st,	Approximate
	IMMEDIATE CAUSE (Finel								Interval Between Onset and Death
	disease or condition resulting in death) s	BUE TO GOR AS A CONSEQUENCE OFF: BUE TO GOR AS A CONSEQUENCE OFF:							
_	_			,	-	foot			1 MTH
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate	DUE TO (OR AS	kd gan	y rente	1 5	7007		-	I MIN
S	Cause. Enter UNDERLYING CAUSE (Disease or injury								
F	that initiated events resulting in death) LAST	DUE TO (DR AS	A CONSEDUENCE OF):					
CER	d								
	PART II. Other significent conditions of	ontributing to deeth	but not resulting in	the underlyin	g ceuse given in		AN AUTOPSY		VERE AUTOPSY FINDINGS
DICAL	Klebsiella j	mermone	a. Atr	al liter	Mahon	1 TYES	DRMED?	0	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME		erload.		U		_			YES 2 12 NO
ä	DID TOBACCO USE CONTRIB	SUTE TO CAUSE	OF DEATH YES	S 🗆 NO 🗉	UNCERTAIN	V 🔲			
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:	26. PLACE OF OEAT						
YSI	1 YES 2 WNO 1	Inpatient 2 ☐ ER/Ou	itpetient 3 DOA	OTHER: 4 - Nursing Hom	e 5 🗆 Residence	6 Other (Specify)			
BY PHYSICIAN:	27. MANNER OF DEATH 1 Venturel 5 Pending	26a. DATE OF INJURY (Month, Day, Year)		IRY WO	RK?	26d. DESCRIBE HOW	/ INJURY OCCU	RED	
	2 Accident Investigation	200 81 405 05 101 111	W 4.5 1		YES 2 ND				
COMPLETED	3 Suicide 8 Could not be datarmined	building, etc. (Sp	RY — At home, farm, at lecify)	reet, factory, offic		281. LOCATION (Stree City or Town, Stat		r Rural Rou	ute Number,
9	29a. CERTIFIER 1 PO CERTIFYING PHYRICIA	N. To the board of		1885 - 776 -					
M M	(Check only one) 1 CERTIFYING PHYSICIAL (Check only one) 2 MEDICAL EXAMINER: (Check only one)								and manner on stated
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUM				
TO BE	7 alwan Balenz.	RESIDENT			P812.		▶ 7	110/	Month, Day, Year)
F	30. NAME AND ADDRESS OF PERSON WHO C				0.74-1.0	c= 1			
		TENG M	INATURE	MUCHS ON	THINTH HOS	or prein	HORE	MI	
	31. DATE FILED (Month, Day, Year)	the Devotes	Rardall						



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Champing

Chapel Hill Convalescent Center

9a. FACILITY NAME (If not institution, give street and number)

1. DECEDENT'S NAME (First, Middle, Last)

Henry

4. SOCIAL SECURITY NUMBER

517-18-1012

CERTIFICATE OF DEATH

NOURS

HENRY H.W. CHAPMAN

YRS.

6. AGE (in yrs. last birthday)

MP

The

DIVISION OF VITAL

use as the burial-transit permit. Pages 1, 2, 3 should DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Randallstown Maryland Baltimore Co. FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10227 Liberty Rd. 21133 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-FORCES? 1 1 YES 2 2 NO 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 TYES 2 TO NO Specify: BY 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retred.) 15. DECEDENT'S EDUCATION pecify only highest grade comple (Spi Elementary/Secondary (0-12) College (1-4 or 5+) 10th Grade Nurseryman 17. FATHER'S NAME (First, Middle, Last) 18, MOTHER'S NAME (First, Middle, Maiden Surname) notified at BE Frederick Chapman Georgina Needham 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 10227 Liberty Rd. Randallstown, MD F. Lucille Chapman 9 20e. METHOD OF DISPOSITION
1 ☑ Burlel 2 ☐ Cremation 3 ☐ Rei
4 ☐ Donation 5 ☐ Other (Specify) 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or must Maryland Veterans Cemetery 7-12 Garrison, Maryland the medical examiner 21. SIGNALULE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 8728 Liberty Rd. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on sech line. IMMEDIATE CAUSE (Final disease or condition reaulting in death) event, to burial, traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST injury. PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL shows any signed Health Alzheiner been of the PHYSICIAN: certificate has been the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) item IE HOSPITAL DR ATTENDING PHYSICIAN: The EUNERAL DIRECTOR: After this certificate of within 72 hours after death with the State DRTANT: If Item 28 is marked, or Item OTHER:
4 Nursing Home 6 Residence 6 Other (Specify) 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 26b. TIME OF INJURY 1 Natural 5 Pending м 1 YES 2 NO BY investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide COMPLETED 6 Could not be 4 [Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITA
TO THE FUNERA
Be filed within 72
IMPORTANT: IS 296. SIGNATURE AND JOYA OF CERTIFIER

MD

OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE in Mudler Radell

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Business

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO. 2. DATE OF DEATH 3. TIME OF DEATH YEAR 425 PM July 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign Jan 28, 1920 California 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Baltimore County Randallstown 10d. INSIDE CITY 1 - YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? -USA 14. RACE — American Indian, Black, White, atc. White 16b. KIND OF BUSINESS/INDUSTRY Chapman Gardens Nursery 20c. LOCATION -- City or Town, State Loring Byers Funeral Directors, Inc. Randallstown, MD 21133 Approximate Interval Batween Onset and Death 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY 1 YES 2 NO 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year)

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TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

							0.000	
FOR 1 - STATE	STATE OF N	MARYLAND / DEPAI			MENTAL HYGIE	NE	-	
REGISTRAR		CERTIF	ICATE OF	FDEATH	REG. N	0.		
1. DECEDENT'S NAME (First, Middle, List) RALPLY	н.	CO	OLE		2. DATE OF DEATH MONTH	DAY	YEAR	3. TIME OF GEATH
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		* 1	PLACE (State or Foreign
217-05-3787	1 🔀 M 2 🗆 F	75 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year)	20	Country)	
9s. FACILITY NAME (If not institution, give si	tract and number)	73	AL OUTY TOWN	OR LOCATION OF D	Jan 6, 19			yland
					EATH		NTY OF DE	
Charlestown Care	Center		Cat	tonsville		Ba.	ltimo	re County
10s. STATE 10b. COUNTY	,	10c. Cf	TY, TOWN OR LOC	ATION				10d. INSIDE CITY
Maryland Balt	imore Co	100		2010				LIMITS?
10e. STREET AND NUMBER	THOIE CO)•		nsville				1 YES 2 NO
Carried Strain	_		1	Of. ZIP CODE		10g. CIT	IZEN OF WH	HAT COUNTRY?
701 Maiden Choice	Lane			21228		USA	A	
11. MARITAL STATUS		IT EVER IN U.S. ARMED	13. WAS DE	ECENDENT OF HISPAI	NIC ORIGIN? (Specify Y	es or No—	14. RACE -	- American Indian, White, etc.
1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE Y	WAR OR DATES	1 YE	S 2 🔯 NO Specif			Specify	
3 ZJ Widowed 4 Divorced		WW 2						White
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Elementary/Secondary (0-12)	College (1-4 or 5	+) life. Do NOT u	work done during nuse retired.)	nost or working	Baltime	ore Ga	as	
12th Grade		Station	ary Engi	ineer	and E	lectri	ic	
17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maide			
Olan J. Coole					. Nickels			
19s. INFORMANT'S NAME (Type/Print)		Lane Manage	0 4000000 (O					01000
SHIP OF STREET					Route Number, City or To		-	21228
Mrs. Betty Faust		719 M	aiden Cr	noice Ln.	Br. 124	Cator	nsvil.	le, MD
20s. METHOD OF DISPOSITION 1 IX Burist 2 G Cremetion 3 Remo 4 Donation 5 G Other (Specify)	oval from Stats	20b. PLACE AND DATE cemetery, crematory or Lorraine	other place) Park Ce	Name of meterv		ocation — odlaw		
21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		22. NAME	AND ADDRESS OF FA			,	
	N	0)	Lorin		Funeral D	irecto	ors,	Inc.
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23. PART LEnter the diseases, pro	omplications the	it caused the death. Do	8728	ng Byers Liberty	Funeral D: Rd. Randa	allsto	own, l	MD 21133 Approximate
ahock, or heart failure.	omplications the	it caused the death. Do	8728	ng Byers Liberty	Funeral D: Rd. Randa	allsto	own, l	Approximate interval Between
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OMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

LOVE LOVE KY, 77 D

REGISTRAR STIGNATURE

DHMH-16 Rev 1/89

MAIDEN CHOICE LA

Jeath. Page 6 may be retained by the hospital or attending physician. funeral director, page 5 should be detached for use as the burtal-transit BALTIMORE, MARYLAND 21215-0020 hours after death. requires that the death certificate be executed within 24 DIVISION OF VITAL RECORDS, P.O. BOX 68760

ysician and completely filled in by the prior to burial, cremation, or removal. the attending physician 1 Mental Hygiene prior to been signed by th has be 23 DIRECTOR: After this certificate hours after death with the State marked, or item 28

Pages 1, 2, 3 should

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CERTIFICATION

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1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) PAUL ANDREW **CURLINGS** 2. DATE OF DEATH 3. TIME OF DEATH o 6 YEAR PAUL DURL INGS 8.50 A 4. SOCIAL SECURITY NUMBER 8. AGE (In vrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year)
July 22,1974 IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign 1 M 2 | F DAYS HOURS 226-37-6372 20 Maryland 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH University of Maryland Medical System Baltimore RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Dale City Virginia Prince William 1 YES 2 X NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 13212 Nickleson Drive 22193 U.S.A. 11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ABMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES WAS OCCENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yee, specify Cuban, Mexican, Puerto Rican, etc.)
 The Yes of Yes of Yes of Yes or No—Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried 3 Widowed 4 Divorced Caucasian 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. OECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) Pool Maintenance Palm Pool 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Ronald Curlings Susan Boldt 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Curlings 13212 Nickleson Drive, Dale City, Va. 22193 20a, METHOD OF DISPOSITION

1 Notice | 2 Cremetton | 3 Removat from State | 4 Donation | 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of July 20c. LOCATION - City or Town, State cemetery, cremetory or other place)
Stonewall Memory Gardens Manassas, Virginia 3.9 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Mountcastle Funeral Home 4143 Dale Blvd., Dale City, Va. 22193 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart felidre. List only one cause on each line. Approximate Interval Between IMMEDIATE CAUSE (Finel **Onset and Death** disease or condition CARIAC resulting in death) SEVERE OUE TO (OR AS A CONSEQUENCE OF): Sequentielly list conditione, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION DF CAUSE 1 TYES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 Inpatient 2 - ER/Outpatient 3 - DOA g Home 5 - Residence 8 - Other (Specify) 26a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Month, Day, Year) 1 Natural 55 M MULTI VEHICLE ACCIDAT 2 DC Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number City or Town, State) 6 Could not be 4 Homicide 10

	STREET	RT15 PM	10161 LEDEWIK TO H
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN 2 MEDICAL EXAMINER: Or	: To the best of my knowledge, death occurred at the time, do the basis of examination end/or investigation, in my opinion	its and place, and due to the cause(e) end me	anner as stated.
296. SIGNATURE AND TITLE OF CERTIFIER S. R. C. C. C. C. C. C. C. C. C. C. C. C. C.	,	D46531	29d. DATE SIGNED (Month, Day, Year) 6 29 95
SUDATHA REDDY, S	HOCK TRAVANA CTR, 2	2 SOUTH GREENE	ST. BALTIMORE.
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SONATURE		

15

THE HOSPITAL (
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IMPORTANT: H

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CERTIFICATION

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1 YES ZENO

5 Pending

6 Could not be determined

27. MANNER OF DEATH

1 Dietural

2 Accident

3 Suicide

4 Homicide 29s. CERTIFIER

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DIVISION OF VITAL RECORDS, P.O. BOA 88/80	OR O	DIRE	hours	item
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	ID THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after or	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical e
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95 20837 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Levie M. Dixon July 9, 1995 4. SOCIAL SECURITY NUMBER 6. AGE (in yrs. last birthday) 6. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 1 🗌 M 2 🙀 F DAYS HOURS YRS. 257 16 9157 79 June 19,1916 Georgia 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR John Hopkins Bayview Medical Center Baltimore RESIDENCE OF DECEDEN 10s. STATE 10b. COUNTY IOc. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Baltimore Dundalk 1 YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7834 Harold Road 21222 U.S.A 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, Whits, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES X 1 Never Married 2 Married Specify: 3 Wildowed 4 Divorced White 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname Will Ramsev Mattie Carathers 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Dixon 1 Taxiway Court Middle River, Maryland 21220 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, Stats 1 Burisi 2 Cremsilon 3 Removal from Stals 4 Donation 6 Other (Specify) Holly Hill Mem. Gardens 7/12/95Baltimore County, Md. 21. BIGHATURE OF FUNERAL BERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Bruzdzinski Funeral Home P.A. . Enter the diseases, or compl 1407 Fastern Ave Baltimore, Maryland 21221 sations that caused the deeth. Do not enter the mode of dying, such ea cerdiac or reapiratory arrest, shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final Onset end Death disease or condition ASYSTOLE MINUTES resulting in death) DUE TO (OR AS A CONSEQUENCE OF): ATHEROSCLEROTIC VASCULAR DISEASE YEARS Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, laeding to immediate cause. Enter UNDERLYING _ HYPERTENSION YEARS CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 100 1 TYES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DO UNCERTAIN

26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL

HOSPITAL: OTHER: I inpatient 2 ER/Outpatient DOA

28e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify)

26s. DATE OF INJURY (Month, Day, Year) Investigation

28b. TIME OF INJURY 28c. INJURY AT М

Home 5 ☐ Residencs 8 ☐ Other (Specify) 28d, DESCRIBE HOW INJURY OCCURED

1 YES 2 NO

21221

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

JULY

10,

CERTIFYING PHYSICIAN: To the best of my knowledgs, death occurred at the time, dats and place, and due to the cause(s) and manner as attated.

2 MEDICAL EXAMINER: On the basis of sxamination snd/or investigation, in my opinion, death occured at the time, dats and place, and dus to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

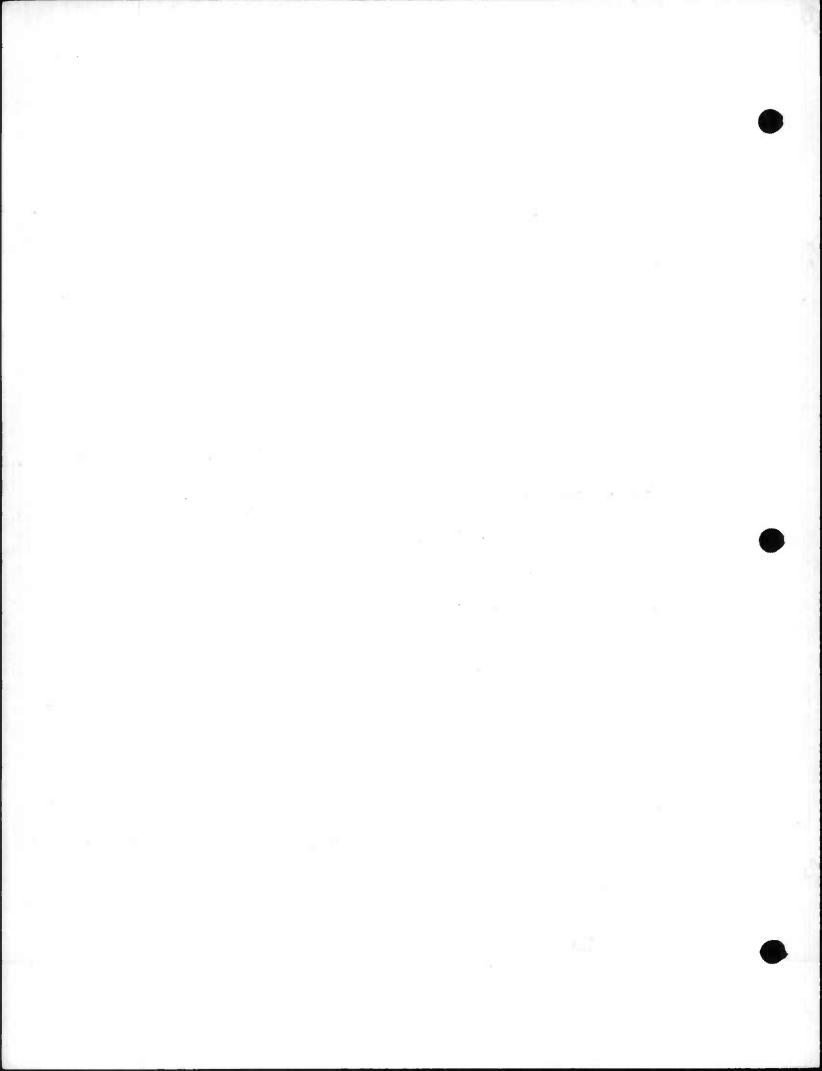
H35593

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAU E OF DEATH (ITEM 27) (Type, Print)

MACE AVE., BALTIMORE, MD. 1124

JOHN J. LOH 31. DATE FILED (Month, Day, Year)

12. REDISTRAN'S SIGNATURE



1 TIME OF DEATH

DHMH-16 Rev 1/89

OYEAR

REG NO

2. DATE OF DEATH

BALTIMORE, MARYLAND 21215-0020

Iteml, 14, Film725, 7/95, 1t

1. DECEDENT'S NAME (First, Middle, Light)

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4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 1 M 2 F Jan.2,1911 217-03-8412 Maryland use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Dulaney Towson Nursing Home Towson Baltimore RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Balto.City, Md. Maryland none 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 600 Light St.Apt.#322 21230 United States rurs after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES Å 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian Black, White, etc. If yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 Never Merried 2 Married BY 1 TYES 2 NO Specify Specify: White Widowed 4 ☐ Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe ğ Elementary/Secondary (0-12) ege (1-4 or 5+) detached 1 6th.Grade none Food Supervisor Mercy Hospital once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumeme) director, page 5 should be to VonHage1 Nicholas Daily Anna BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 9 Mrs.George Kloid 700 Hollen Rd. Balto. Md. 21212 3 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must DATE Mariel 2 ☐ Cremation 3 ☐ 4 ☐ Donation 6 ☐ Other (Specify) Burlel 2 Cremation 3 Removal from State Cross Cemetery, 7/10/ 95 Brooklyn Pk.Md examiner 21. SIGNATURE OF FÜNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY funeral Balto.Md.21230 McCully Funeral Home, 130 E. Fort Ave filled in by the fon, or removal. medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, Approximate shock, or hasrt fellure. List only one cause on such line 10 Interval Batween IMMEDIATE CAUSE (Finel Onset and Death I completely filler rial, cremation, (# DUE TO (OR AS A CONSEQUENCE OF): disesse or condition resulting in death) event, executed prior to burial, traumatic CERTIFICATION and Sequentially list conditions. if sny, leading to immediate physician e e cause. Enter UNDERLYING CAUSE (Disease or injury certificate other Mental Hyglene that initiated events resulting in death) LAST attending 10 death shows any Injury, the PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. requires that the MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS signed by the AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO certificate has been the State Dept. of I PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Hem EXAMINER? HOSPITAL: QTHER: 1 YES 2 0 OR ATTENDING PHYSICIAN: 1 | Inputient 2 | ER/Outputient 3 | DOA Nursing Home 5 Residence 6 Other (Specify) 10 the 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 28 Is marked, with this 1 Netural 5 Pending 1 YES 2 NO DIRECTOR: After to hours after death BY Accident Investigation 28e. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 3 Suicide 28t, LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide e FUNERAL DIN.
within 72 hours.
VT. If Itom 29 29e. CERTIFIER 1 XCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as attated. MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner se stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29st. DATE SIGNED (Month, day, Year) BE Doanno 90 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Baltimore 2822 Day 31. DATE FILED (Month 32. REGISTRAR'S SIGNATURE

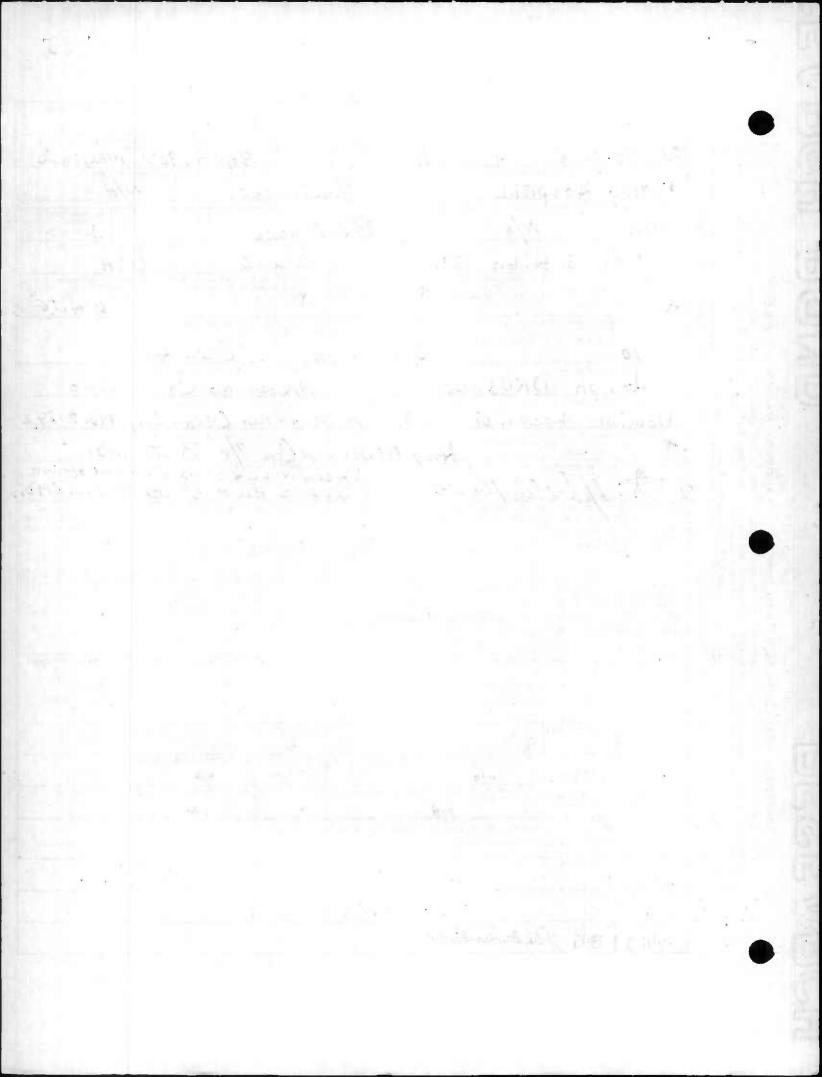
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MI	ENTAL HYGIENI
CERTIFICATE OF DEATH	REG. NO.

1	1. OECEDENT'S NAME (First, Middle, Last	lia	CERTIFIC	ALL OI	DLAIII	1 1	DAY YE	3. TIME OF OEATH	
	4. SOCIAL SECURITY NUMBER 212-74-3138	5. SEX 8. AGE		F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN,	7. DATE OF BIRTH (Morith, Day, Year)	8.	BIRTHPLACE (State or Foreige Country) MARYLAND	
TOR	90. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH								
DIRECTOR	10e. STATE 10b. COUN	N/A	N/A BALTIMON				E :		
FUNERAL	309 S,		T.	101	2120	2	10g. CITIZEN	OF WHAT COUNTRY?	
D BY FU	11. MARITAL STATUS 1 Never Merried 2 Merried Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 _ YES IF YES, GIVE WAR OR	3 2 NO	13. WAS DEC	cify Cuben, Mexica	NC ORIGIN? (Specify Your, Puerto Rican, etc.)	se or No— 14.	RACE — American Indian, Black, White, atc. Specify: WHITE	
COMPLETE	15. DECEDENT'S ED (Specify only highest gran Elementary/Secondary (0-12)	College (1-4 or 5+)	16e. DECEDENT'S US (Give kind of wor life. Do NOT use i	k done during mo. retired.)	ON st of working	Own	HO M	TRY E	
100	17. FATHER'S NAME (First, Middle, Last)	DRUSAN			ANGE	ME (First, Middle, Meide LINA	OSSE	NTINO	
TO BE		CONARDI	13600	N.0	CEAN R	Acute Number, City or To	N CiTy	MD. 2184	
	20e. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	LLY RE	DEEM	FR CEM	7/8 B	ALTO-	or Town, State	
1	Della Noce # SONS FUNERAL SERVICE LICENSEE 3 22 S. HiGH ST. BOLTO 21202 M								
	23. PART I. Enter the diseases, or shock, or heart failure IMMEDIATE CAUSE (Finel disease or condition resulting in death)	a. Conges	ach line.	enter the mo	Failu	ve		Interval Battonset and I	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. S/P Surgery for Small bowel obstruction II day OUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):								
	PART II. Other significant condition						N AUTOPSY DRMED?	24b. WERE AUTOPSY FIND AVAILABLE PRIOR TO	
MEDICAL C						1 🗆 YES	2 NO NO		
MEDIC	25. WAS CASE REFERREO TO MEDICAL EXAMINER?	HOSPITAL:		THER:	ACE OF DEATH (Ch	eck only one)	2 N NO	OF DEATH?	
HYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	1) Inpetient 2 ER/Ou 26e. OATE OF INJURY (Month, Pey, Year)	tpatient 3 DOA 4	OTHER: Nursing Hom OF 26c, INJ	e 5 🗆 Residence			COMPLETION DF CAU OF DEATH? 1 YES 2 NO	
ETED BY PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be datermined	26e. PLACE OF INJURy building, etc. (Sp	26b. TIME (INJUR	OF 26c. INJI M 1 1 Y	e 5 Residence URY AT RK? 'ES 2 NO	eck only one) 6 Other (Specify)	INJURY OCCURI	COMPLETION DE CAL OF DEATH? 1 YES 2 NO	
LETED BY PHYSICIAN: MEDIC	25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 1 CERTIFYING PHY ONE) 2 MEDICAL EXAMIN	26e. PLACE OF INJURY (Month, Pey, Year) 26e. PLACE OF INJURY building, atc. (Sp SICIAH: To the best of my kno	ty—At home, farm, stre	OTHER: Nursing Homory Port 26c, INJ. IY WO M 1 7 Y Neet, tectory, office	e 5 Residence URY AT RK? /ES 2 NO	eck only one) 6 Other (Specify) 26d. DESCRIBE HOW A 26t. LOCATION (Street City or Town, State N to the ceuse(e) end me	INJURY OCCURI	COMPLETION DF CAU OF DEATH? 1 YES 2 NO ED For a second	
TED BY PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be datermined 29e. CERTIFIER Check only 1 CERTIFYING PHY	26e. OATE OF INJURY (Month, Pey, Year) 26e. PLACE OF INJURY (Month, Pey, Year) 26e. PLACE OF INJURY (Month, Pey, Year) 26e. PLACE OF INJURY (Month, Pey, Year) 26e. PLACE OF INJURY (Month, Pey, Year) 26e. PLACE OF INJURY (Month, Pey, Year) 26e. PLACE OF INJURY (Month, Pey, Year)	tpatient 3 DOA 4 28b. TIME (INJURITY — At home, farm, streecify) wiedge, death occurred ion end/or investigation,	OTHER: Nursing Horn Property 26c, INJ, 197 Notes, tectory, office at the time, date In my opinion, delications, delic	e 5 Residence URY AT RK? /ES 2 NO	eck only one) 6 Other (Specify) 28d. DE\$CRIBE HOW PA 28t. LOCATION (Street City or Yown, State to the ceuse(e) end metime, date end place, e	end Number or F	COMPLETION DE CAU OF DEATH? 1 YES 2 NO ED Rural Route Number,	



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

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296. SIGNATURE AND TITLE OF CERTIFIER

ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print,

July 32 TESTS PARS CONTUC

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the time all director, page 5 should be detached for use as the burial-transin nermit Panes 1, 2 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or memoral.
IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical anaminer must be notified at once.

ITEMS: 6. PER F.H. FILM G-726 8/31/95 t.t FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last, 2. DATE OF DEATH 3. TIME OF DEATH July 2,1995 YEAR Madeline Davidson 7:45pm 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH S. BIRTHPLACE (State or Foreign March 8,1917 013 07 9493 1 M 2 SF 77 78 YRS. HOURS Massachusetts 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR 8811 Colesville Road, Silver Spring Montgomery RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Silver Spring 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8811 Colesville Road, #424 20910 USA WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yee or Noit ves, specify Cuban, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Married It yes, specify Cuban, Mexican, Pu 1 YES 2 NO Specify: BΥ 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) David Sedersky Emma Solomon 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Morris Davidson same as #10 above 20s. METHOD OF OISPOSITION
1 Surial 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND OATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State United Hebrew Cem. 7/4/95 Baltimore, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY IVES-Pearson Funeral Homes Falls Church, VA 22046 23. PART I. Enter the diseases, or complicatione that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete ehock, or haert failure. List only one cause on each ilne. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) ator over 00 VP 2 months Sequentielly list conditions. DUE TO If any, landing to immediate cause. Enter UNDERLYING decades CAUSE (Disesse or Injury that initieted evente resulting in desth) LAST PART II. Other algorificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a, WAS AN AUTOPSY 24b. WERF AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? yponatremia and Inappropriate 1 - YES 2 NO syndrome 1 - YES 2 - NO 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4 | Nursing Home 5 | Reeldence 6 | Other (Specify) 1 YES 2 NO 1 Inpstient 2 ER/Outpatient 3 DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident 1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 4 Homicide 29e. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 2 __ MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

29c. LICENSE NUMBER

46101

Povar 8700 Georgia Avenue, Suite 400, Silver Spring, Maryland

29d. DATE SONED Month, Day, Year)

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

Pitt. OR ATTENDING PHYSIC After DIRECTOR. FUNERAL WITHIN 72 1 STANT: II 1 HOSPITAL. TO THE HOSPITE TO THE FUNESA De filed within 7 IMPORTANT: I

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	utilities has been signed by the attending physician and competiely fleed in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3		
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CAN THE PROPERTY THE PROPERTY OF THE CASE OF THE CASE OF THE PROPERTY PAGE 6 MAY BE TRAINED BY THE HOSPITAL OF Attending physician.	De c		or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 13.04 bu JUIL 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday 7. DATE OF BIRTH (Month, Day, Yea IF UNDER 1 YEAR IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign 213-14-9406 DAYS 73 1 M 2 X F Jan. 5,1922 Maryland 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF CEATH DIRECTOR St. Agnes Hospital Baltimore N/A RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Catonsville 1 YES 2XX NO FUNERAL 812 Southridge 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Road 21228 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 MNO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 Never Married 2 Married BY 1 YES 2X NO Specify: Specify: White 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) Salesperson Retail 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Frederick Cavey Virgie Molesworth BE 19a. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number of Rural Route Number, City or Town, State, Zip Code)
812 Southridge Road Catonsville, Maryland 21228 2 Harvey Fritter (Spouse) 20s, METHOD OF DISPOSITION

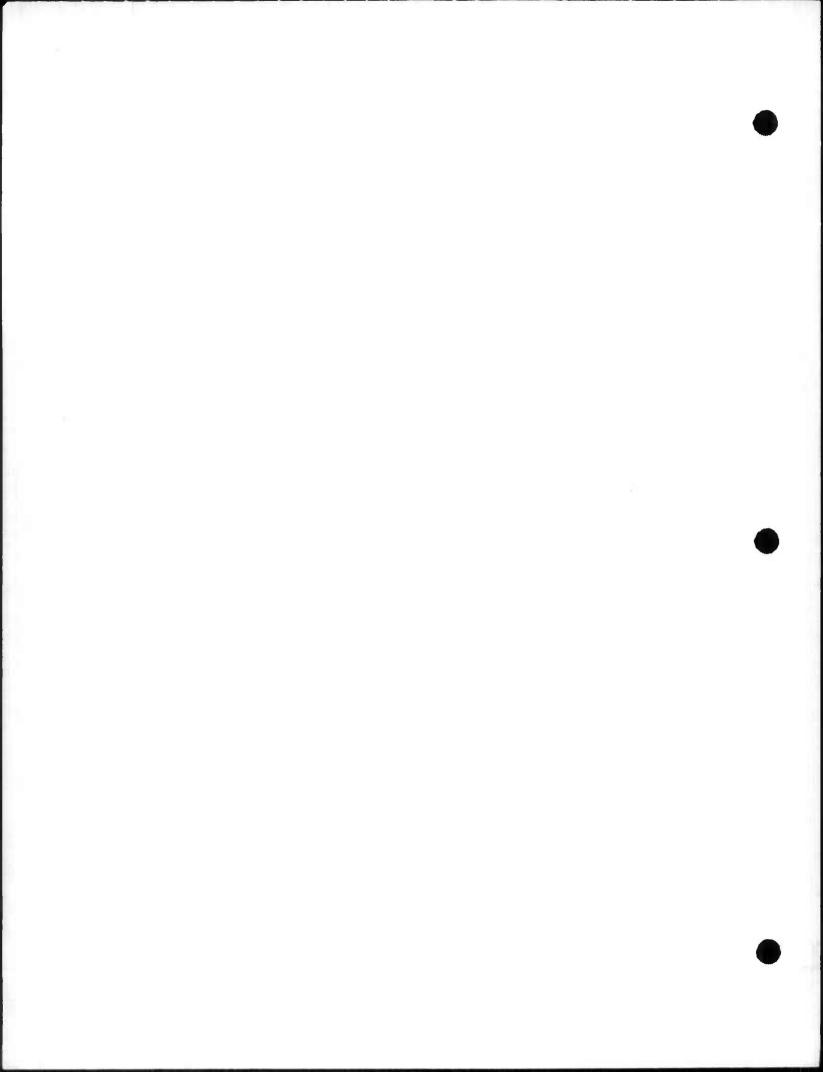
1 25 Burlel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (NoT OF 1) 8, 1995TE 20c. LOCATION - City or Town, State Lorraine Park Cemetery Woodlawn, Maryland 21. SIGNATURE OF SUMERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes Lecus Con 1630 Edmondson Avenue Catonsville, Maryland 23. PART I. Enter the discesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) Arter + Disesse COYOWARY DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initisted events resulting in deeth) LAST PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS CHROWIC Failure AWAILABLE PRIOR TO RENAL COMPLETION OF CAUSE 1 TYES 2 NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HQ6PITAL: OTHER 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Nome 5 Residence 8 Other (Specify) 27. MANNER OF GEATN 28b. TIME OF INJURY 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. OEŞCRIBE HOW INJURY OCCURED 1 M Natural 1 YES 2 NO BY 2 Accident Investigation 28a. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Spec/fy) 3 Sulcida 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 29e. CERTIFIER (Check ant/) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, dasth occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNEO (Month, Day, Year) luces my 021267 6,1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Maiden Lane Suite Lone 201

Baltimore, mD 21228

31. DATE FILED (Month, Day, Year) 32 REGISTRAR'S SIGNATURE 1 1995



DIVISION OF VITAL RECORDS, P.O. BOX 68760

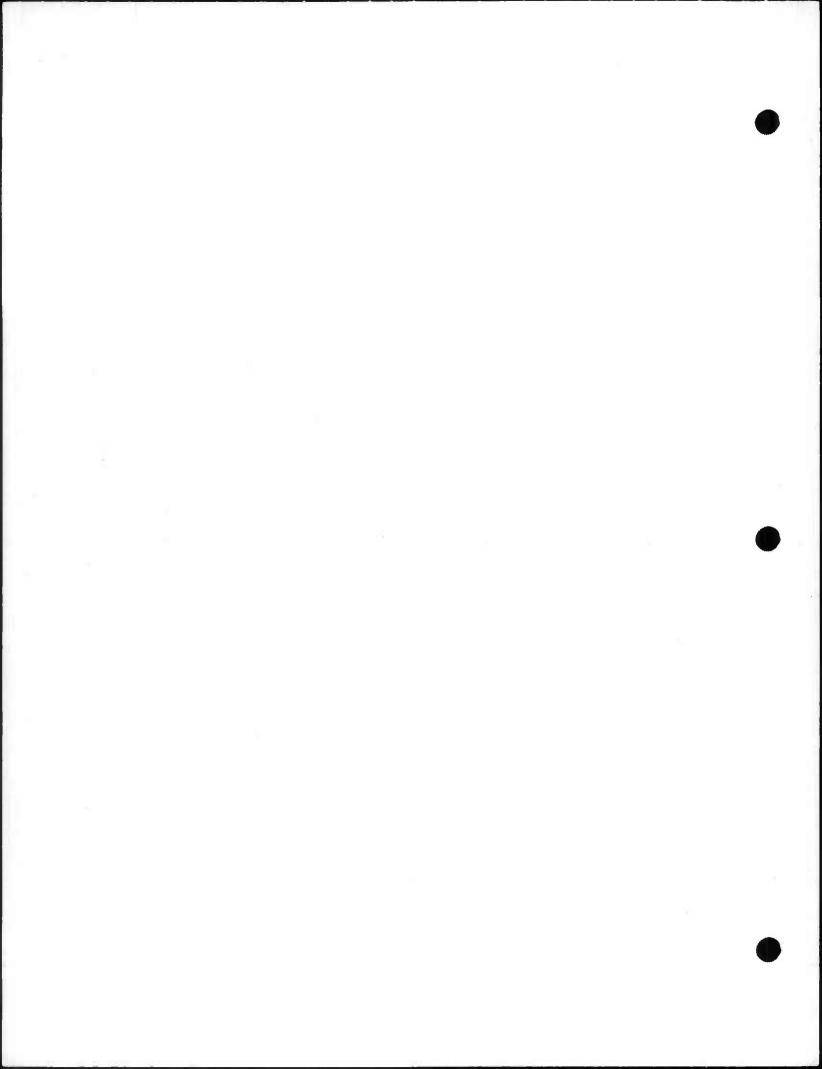
	Page		
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page	ied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ORTANE if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be markful at once

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		FOR 1 - STATE REGISTRAR	STATE OF MARYLAN	ID / DEPAR	ITMENT OF I	HEALTH AND I		IE .	Sa PRS 1867 There
		1. DECEDENT'S NAME (First, Middle, Last)		CENTIF	ICATE OF	DEATH	REG. NO	<u> </u>	3. TIME OF DEATN
)	R	TERRELL 4. SOCIAL SECURITY NUMBER	A .		FORE	7	JUNE 30	, 199	5 6:49 PM
P		218-02-4332	1 M 2 D F 12	rrs. last birthday) YRS.	F UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year) 01/11/1		BIRTHPLACE (State or Foreign Country) MARYLAND
3 should		90. FACILITY NAME (If not institution, give so JOHNS HOPKINS				OR LOCATION OF DE		9c. COUNTY	OF DEATN
es 1, 2,	ECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	105F11AL BAL1				10d. INSIDE CITY		
mit. Pag	L DIRI	MARYLAND 10s. STREET AND NUMBER	N/A	B	ALTIMOR				1 X YES 2 NO
n. Insit per	FUNERAL		ETTE STREET		10	21205			N OF WHAT COUNTRY?
hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, or removal. medical examiner must be notified at once.	BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U	2)(10	If yes, s	CENDENT OF NISPAN	IIC ORIGIN? (Specify Yes n, Puerto Rican, atc.)	s or No- 14	. RACE — American Indian, Black, White, etc. Specify:
tending s as the	ED	18. DECEDENT'S EDUC	CATION 16	Sa. DECEDENT'S	USUAL OCCUPATI	ON	16b. KIND OF BU	SINESS/INDUS	BLACK
oital or atte	<u></u>	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of a life. Do NOT us	work done during ma se retired.)	ost of working	N/		
he hospit detached once.	COMPL	17. FATHER'S NAME (First, Middle, Last)	0	STUDI	ENI	1e. MOTNER'S NA	ME (First, Middle, Maiden		
d by th	BE C	CHARLES FORBES				BRIGI	TTE JACK	SON	
5 should	6	19e. INFORMANT'S NAME (Type/Print)					Route Number, City or Tow	m, State, Zip Co	ide)
ay be		BESSIE MOORE 3530 RESOURCE DRIVE							
e 6 ma ector, i		1 X Burlel 2 Cremation 3 Reme 4 Donation 8 Other (Specify)	oval from State cemete	rv, crematory or o			DATE 200. LO		IMORE, M.D.
after death, Page 6 m by the funeral director, smoval.		21. SIGNATURE OF JUNERAL SERVICE LIC		101	22. NAME A	ND ADDRESS OF FA	CILITY		
ter dear the fun yval.		Lovert L. Kuss				2222 WEST NORTH AVENUE BALTO, M.D.			
d in by the or removal.		23. ART I. Enter the diseases, or dehock, or heart fellure.	complications that caused the Liet only one cause on each	ne deeth. Do r n line.	not enter the mode of dying, auch as cerdiec or respiratory arrest, Approximate Interval Between				
E 6 €		IMMEDIATE CAUSE (Finel disease or condition	GUNSHOT W	WOUND OF HEAD					Onset and Deeth
		resulting in death)	DUE TO (OR AS A CO						
and and	ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CO	ONSEDUENCE OF	F):				
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attend attend mtal Hy	EH		d						
OR ATTENDING PHYSICIAN: The law requires that the death certificate be in DIRECTOR: After this certificate has been signed by the attending physician roous after death with the State Dept. of Health and Mental Hygiene prior to tem 28 is marked, or Item 23 shows any Injury, or other traun	EDICAL	PART II. Other significent condition	a contributing to deeth but	not resulting	in the underlyin	g cause given in	Part I. 24a. WAS AN PERFOR	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
has been sign Dept. of Hea	AN: M	DID TOBACCO USE CONTE	RIBUTE TO CAUSE OF	DEATH YE	S NO [UNCERTAIN			1 YES 2 NO
PHYSICIAN: The law this certificate has I with the State Dept rked, or item 23	SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. HOSPITAL:	PLACE OF DEAT	IN (Check only one)				
certificant the St	PHYSI	1 X YES 2 NO 27. MANNER OF DEATN	1 Xinpatient 2 ER/Outpatie		4 - Nursing Hon	ne 5 🗆 Residence			
DING PHYS After this of death with s marked,	ВУ Р	1 Netural 5 Pending 2 Accident Investigation	286. DATE OF INJURY 286. IM W W 06 / 29 / 1995 11:15 PM 1			INJURY AT 28d. DESCRIBE NOW INJURY OCCURED WORK? YES 2 XNO SUBJECT SHOT			
OR ATTENDING DIRECTOR: After hours after death Item 28 is ma	ETED	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) RESIDENCE			281. JOCATION (Super and Number or Bural Route Number 2410) For FAYETTE STREET BALTIMORE, MARYLAND			
							to the cause(s) and mer	ner as stated.	
	COMP	one) 2 XMEDICAL EXAMINE	R: On the basie of axamination er	nd/or investigatio	n, in my opinion, o	feath occured at the	time, date end place, en	d due to the c	ause(e) end manner ee stated.
THE HOSPI THE FUNEF filed within PORTANT:	BE (29b. SIGNATURE AND TITLE OF CERTIFIER	A UI A	1		29c. LICENSE NUM	-711		GNED (Month, Day, Year)
2 2 3 3	0	Margarita his Holl				O.C.M.E. JULY 10, 1			Y 10, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M.D. 111 Penn Street, Baltimore, Maryland 21201

pr. negistran's signature

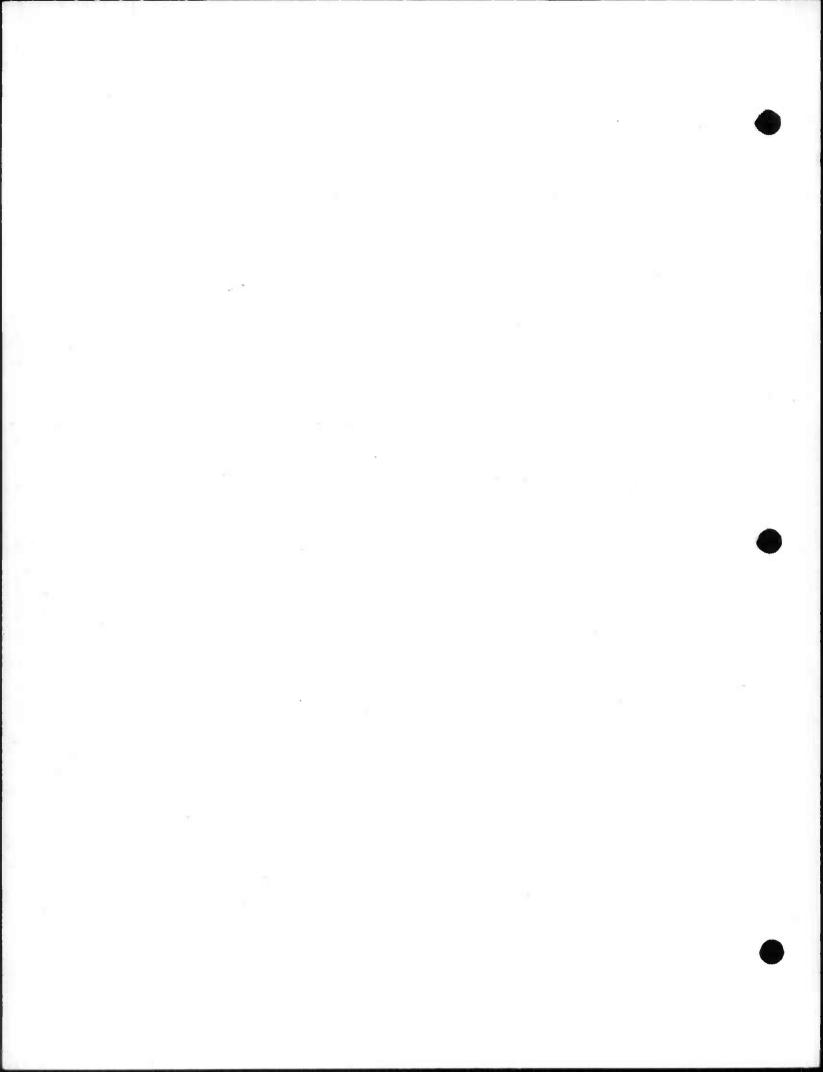
A Character Maryland 21201 Margarita Korell
31. DATE FILED (Month, Day, 1995
JUL 1 1995



DIVISION OF VITAL RECORDS, P.O. BOX 68760

burial-transit permit. Pages 1, 2, 3 should	
ettor, page 5 should be detached for use as the	must be notified at once.
and completely filled in by the tuneral dire to burial, cremation, or removal,	ld, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
is been signed by the attending physician spt. of Health and Mental Hygiene prior to	23 shows any injury, or other traus
E FUNERAL DRECTUR: After this certificate had within 72 hours after death with the State D	RTANT: If item 28 is marked, or Item 2
	D THE FUNETAL DRECTUR. Then this certificate has been signed by the attending physician and competitive filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after with the State Dept. or Health and Mental Hygiene prior to burial, crempate, or removal.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI	MENT OF H	IEALTH AND I	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last,)			- DEPART	2. DATE OF DEATH		3. TIME OF DEATH	
	GODFREY	FREDERICK	FUNK			JULY 9.	1995		Рм
	4. SOCIAL SECURITY NUMBER			F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	6. BIRT	HPLACE (State or Foreig	~
	219-18-7940	1 🖟 M 2 🗆 F	69 YRS. M	ONTHS DAYS	HOURS MIN.	(Month, Day, Year) OCT 28, 1	925 MAE	(7) RYLAND	
	Se. FACILITY NAME (If not institution, give	street and number)	9	b. CITY, TOWN (OR LOCATION OF DE		9c. COUNTY OF		
DIRECTOR	8 FRANKLIN TREE	COURT		CATONS	VILLE		BALT	IMORE	
Ä	10e. STATE 10b. COUN	ry	10c. CITY, 1	TOWN OR LOCAT	TION			10d. INSIDE CITY	
	MARYLAND 1	BALTIMORE		CATONSV	ILLE			LIMITS?	
8	10e. STREET AND NUMBER			101	. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?	
	8 FRANKLIN TREE	COURT			21228		U.S	.A.	
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EYER I FORCES? 1 XYES IF YES, GIVE WAR OR C		If yes, sp	ENDENT OF HISPAN ecity Cuben, Mexical 2 NO Specify	IIC ORIGIN? (Specify Yes n, Puerto Rican, etc.)	or No — 14, RAC Blac Spec	E — American Indian, ck, White, etc.	
ETED	15. DECEDENT'S ED (Specify only highest grad	UCATION le completed)	16a. DECEDENT'S US (Give kind of work life, Do NOT use n	k done durina ma	ON st of working	16b. KIND OF BUS	INESS/INDUSTRY		\dashv
ا ٿ	Elementary/Secondary (0-12)	College (1-4 or 5 +)			NT	CTA	TE FARM		
COMPL	17. FATHER'S NAME (First, Middle, Last)		INSURA	NCE AGE		ME (First, Middle, Maiden			
		JNK				RINE BRENN			
2	19e. INFORMANT'S NAME (Type/Print)	71110	19b. MAILING AD	DRESS (Street e		NAME DESIGNATION OF TOWN			-
2	JEANNE MURPHY FUR	VK.	1			, CATONSVI		21228	
	20g. METHOD OF DISPOSITION	201	D. PLACE AND DATE OF	DISPOSITION /Na	me of	DATE 20c 10	CATION City or T		\dashv
	*CXBuriel 2 Cremetion 3 Rer 4 Donation 5 Other (Specily)	novel from State Cer	netery, crematory or other OUDON PARE	CEMET	ERY. JUL	13 BAT	TIMORE.	MARYLAND	
	21. SIGNATURE OF FUHERAL BERVICE L	ICENSSE /		22. NAME AN	ID ADDRESS OF FAC	CILITY			
- 1	Mulles -	Harle				ON FUNERAL AVE., BAL			- 1
	23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	. Non S	d the death. Do not such line.	enter the mo	-	as cardiac or respi		Approximate Interval Betwoonset and De	reen
CENTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A	A CONSEQUENCE OF):				\		
PART II. Other significant conditions contributing to death but inot resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY MARABLE PRIO COMPLETION OF DEATH O							WERE AUTOPSY FINDIN MARLASLE PRIOR TO COMPLETION OF CAUS OF DEATH?		
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	35. PLACE OF DEATH	The state of the s		/			\neg
	1 □ YES 2 W NO	1 Dispetient 2 DEN/Outs		THER: Number Home	Belidence	8 C) Other (Specify)			
L	27. MANNER OF DEATH 1 Natural S Pending Investigation	26e. DATE OF INJURY (Month, Day Weer)	295. TIME O	WO	URY AT RKP TES 2 NO	28d. DESCRIBE HOW B	NUMY OCCURED		
IED B	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide delapmined	28e. PLACE OF INJURY building, etc. (Spe	r — At home, farm, stre- city)	et, factory, affice		28f. LOCATION (Street a City or Reen, State)	nd Number or Hurel	Route Number	\dashv
OMPLE		SICIAN: To the best of my know ER: On the basis of examinatio						e) end manner ee stated	d.
200	296. SIGNATURE AND YOUR OF CERTIFIE				29 LICENSE NUM		29d. DATE SIGNED		<u> </u>
1	30. NAME AND ADDRESS OF PERSON W	D COMPLETED CAUSE OF DE	3 3 2		Man	Avono	Bulk	ma MI	Ħ
	31. DATE FILED (Mover, Day hear)	Dalin d'authe	or hardall				1	7	\dashv



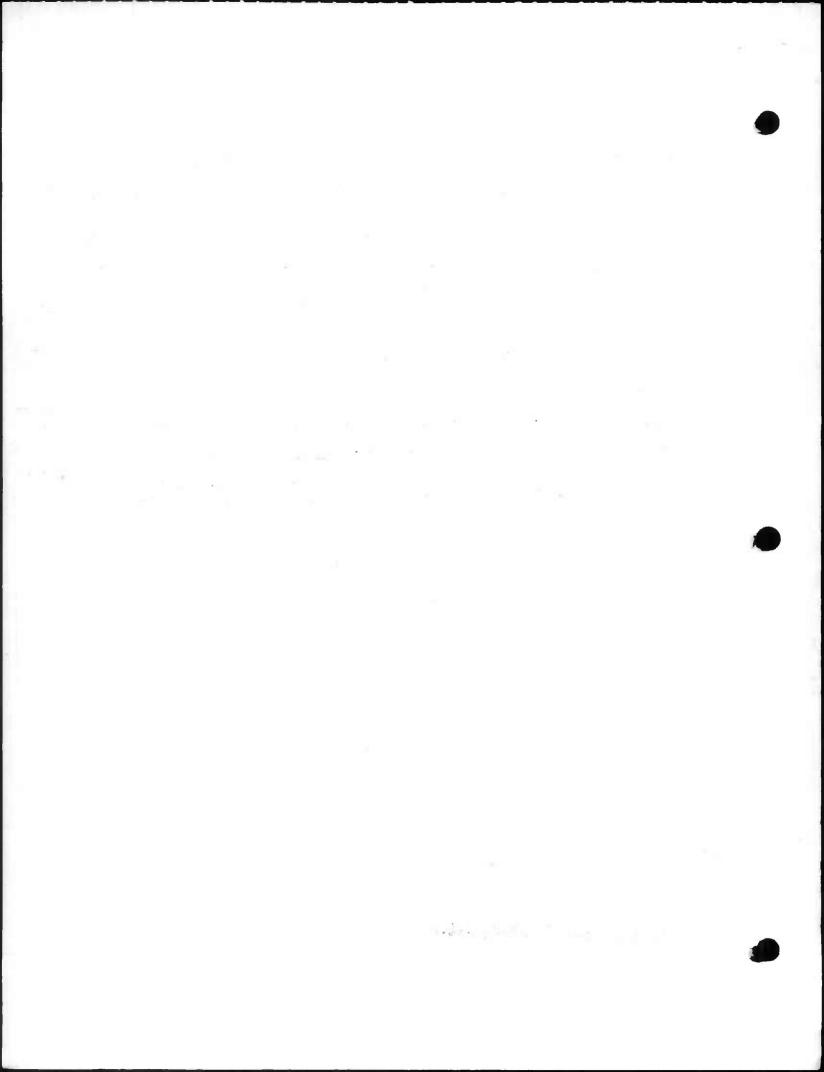
DIVISION OF VITAL RECORDS, P.O. BOX 68760.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the Year flows after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR

	- REGISTRAR	CERTIFIC	ATE OF	DEATH	REG. NO		
	1. DECEDENT'S NAME (First, Middle, Last)	6.3			2. DATE OF OEATH		3. TIME OF DEATH
	Margaret Lician	Flynn			Manager 19 19 19 19 19 19 19 19 19 19 19 19 19		995 4:30 a
			F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		B. BIRTHPLACE (State or Foreign
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	9a. FACILITY NAME (If not institution, give street and number)	91	b. CITY, TOWN O	R LOCATION OF DE			TY OF DEATH
H	STELLA MARIS HOSPI	CE	Tour	50N			LTIMORE
DIRECTOR	RESIDENCE OF DECEDENT		1000	JON		- OF	MINDER
HE	10a. STATE 10b. COUNTY		TOWN OR LOCAT				10d. INSIDE CITY LIMITS?
	MARYIAND BALTIMORE CI	TY	BALT	IMORE			1 YES 2 NO
AL	10e. STREET AND NUMBER		101.	ZIP CODE		10g. CITIZE	EN OF WHAT COUNTRY?
EH	113 SOUTH POPPLETON S	STREET		21201		U	1.5A.
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER	IN IIS ADMED			IC ORIGIN? (Specify Yes	or No — 1	4. RACE — American Indian,
ВУ	1 Never Married 2 Married FORCES? 1 YES IF YES, GIVE WAR OR I	DATES	1 TYES		n, Puarto Rican, etc.)		Black, While, alc. Specify:
			<u> </u>	/ -			WHITE
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	18a. DECEDENT'S US (Give kind of work	k done during mos	N it of working	16b. KIND OF BU	SINESS/INDU	STRY
E	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT use re	-		5-5-1-		
MP	12	BANK	< IEL	LEE	EQUI	IABL	E TRUST
8	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NA	ME (First, Middle, Maiden	Sumame)	
B	JAMES J. FLYN			MAR	Y DOI	HAL	OE
6	19a. INFORMANT'S NAME (Type/Print)		Different Contract Co		Toute Number, City or Tow	n, State, Zip C	
	LANNE MARIE FLYND	1 15 RO	BINK	IDGE	COURT	TARK	VILLE MD.
	Burial 2 Cremation 3 Removal from State Co	b. PLACE AND DATE OF D melery, crematory or other		me of	- 44		ty or Town, Stata
	4 U Donation 5 U Other (Specify)	YOLY RE	DEEME	ER_	7-15 B	ALTIN	NORE, MO.
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	0	22. NAME AN	D ADDRESS OF FA	BEOD	HAR	FORD ROAD
	Charles -tr Eines	Si.	PARI	KVILLE	MD. Z	1234	5-1
	23. PART I. Enter the diseases, or compilcations that cause	d the deeth. Do not	enter the mod	de of dying, suc	n as cerdiec or respi	ratory arres	st, Approximate
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	reaulting in death) s. OUE TO (OR AS	A CONSEQUENCE OF):	-				
z		A CONSEQUENCE OF):	25 - 4 2 2	dise	real		İ
2	Sequentially list conditions, If any, leading to immediate	CONSEQUENCE OF):	/				
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	thet initieted events DUE TO (OR AS	A CONSEQUENCE OF):					
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AN	DID TOBACCO USE CONTRIBUTE TO CAUSE C			UNCERTAIN	1 □		
ō	EXAMINER? HOSPITAL:	26. PLACE OF DEATH (THEB:				
PHYSICIAN: ME	1 ☐ YES 2 ☑ NO 1 ☐ Inpetiant 2 ☐ FUOL 27. MANNER OF DEATH 258. OATE OF INJURY	-			6 Other (Specify)		
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B⊀	2 Accident Investigation	Y — At home, larm, stree		ES 2 NO			
	3 Suicida 8 Could not be detarmined 28a. PLACE OF MJUR building, etc. (Spe	r — At nome, Isrm, street	el, lactory, offica		261. LOCATION (Street a City or Town, State)	and Number or	Rural Route Number,
COMPLETED	29e, CERTIFIER						
AP.	(Check only 1 KCERTIFYING PHYSICIAN: To the beat of my know						
Š	2 MEDICAL EXAMINER: On the basis of examination	or and/or investigation, is	In my opinion, de	ath occured at the	lime, deta and place, an	d dua lo tha	cause(s) and manner as stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIER			29c LICENSE NUN	BER		SIGNED (Month, Day, Year)
TO B				29¢ CICENSE NUN	004		10 95
F	30. NAME AND APPRESS OF PERSON WHO COMPLETED CAUSE OF OR	EATH (ITEM 27) (Type, Pri	int) (, Clelle	7 Res	201-	6
			ואב וטקיי	2		C120	7
	31. DATE FILEO (Month, Day 1995 Jul 32. DASTRESS	WHELL.					



MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

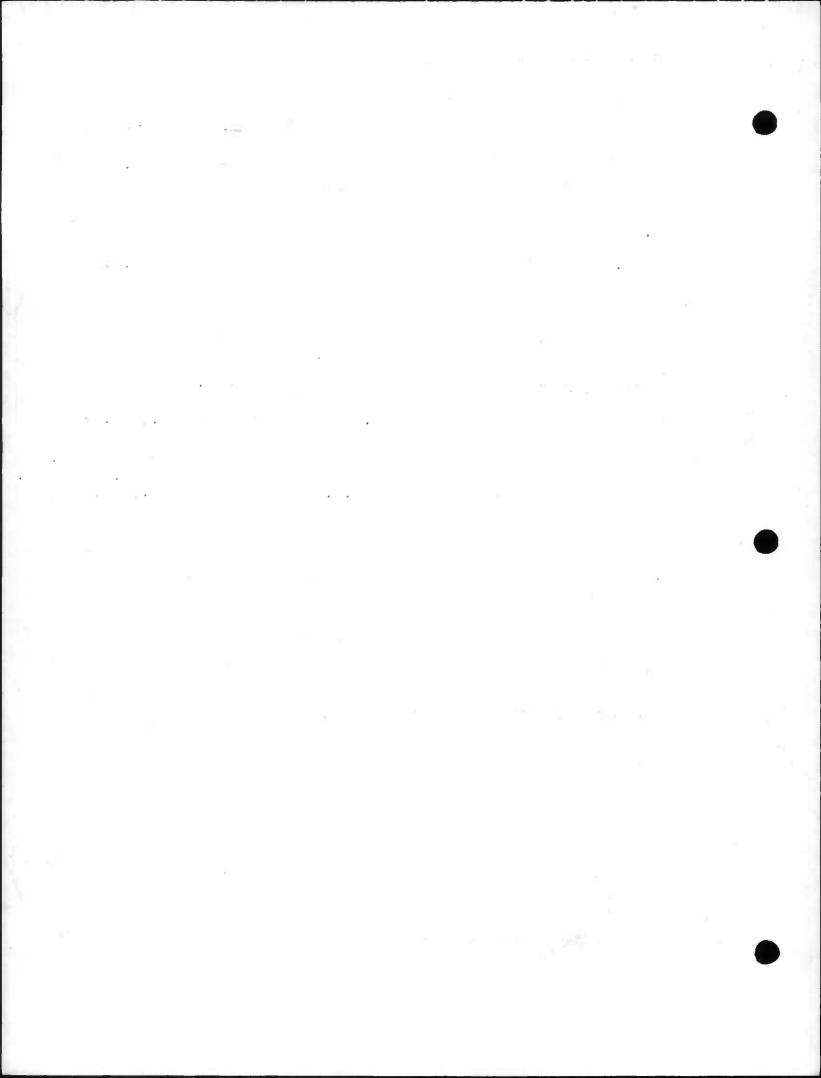
FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH FLUSS OSEPH 1995 11:15 JULY 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. (Month, Day, Year) APR. 21, HOURS 1 M 2 | F YRS 061-09-7540 190\$ NEW YORK Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b, CITY, TOWH OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR CHARLESTOWN RETIREMENT COMMUNITY CATONSVILLE BALTIMORE RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY
LIMITS?
1 YES 2 NO CATONSVILLE MARYLAND BALTIMORE permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? ours after death. Page 6 may be retained by the hospital or attending physician. If in by the funeral director, page 5 should be detached for use as the burial-transit 715 MAIDEN CHOICE LANE, APT. 518 21228 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. If yes, specify Euben, Mexican, Puerto Ricen, atc.)

1 YES 2 NO Specify: 1 Never Merried 2 Merried BY Specify: 3 ♥ Widowed 4 □ Divorced WHITE WWII 9 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Olve kind of work done during most of working life. Do NOT use retired.) 16b, KIND OF BUSINESS/INDUSTRY (Specify only highe ᆸ Elementery/Secondery (0-12) College (1-4 or 5+) COMPL ACCOUNTANT ACCOUNTING once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) MAX To S FLUSS SOPHIE MATE BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MR. JONATHAN FLUSS 7434 GAITHER ROAD SYKESVILLE, MD 21784 BALTIMORE, eg 20e. METHOO OF DISPOSITION
1 Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must emelery, cremetory or other place.
ARLINGTON—CHIZUK AMUNO - 7-10-1995 BALTIMORE, 4 Donation 5 Other (Specify) . the medical examiner 21, SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. lense QU and completely filled in by the bunal, cremation, or removal. 6010 REISTERSTOWN ROAD BALTIMORE MD 21215 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on sech line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) weels event, DUE TO (OR AS A CONSEQUENCE OF): laure Onemio prior to burial. month traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): physician : If any, leading to immediate OR ATTENDING PHYSICIAN: The law requires that the death certificate be himic real march ceuse. Entar UNDERLYING insufferious CAUSE (Disease or Injury other the attending phy Mental Hygiene p DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 Injury, signed by the a PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL Stole 2/93. PERFORMED? AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO has been : DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\square\) NO \(\sqrta\) UNCERTAIN \(\sqrta\) PHYSICIAN: Item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h EXAMINER? HOSPITAL: OTHER:
4 Nursing Home 5 Residence 8 Other (Specify) 1 TES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA the or 27, MANNER OF DEATH 28c. INJURY AT WORK? 26e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28d, DESCRIBE HOW INJURY OCCURED this c 28 is marked, 1 Natural 1 YES 2 NO BY After Investigation Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street end Number or Rural Route Number, City or Town, State) 6 Could not be DIRECTOR: / COMPLETED 4 Homicide Item 29e, CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner as stated. TO THE HOSPITAL OF TO THE FUNERAL D be filed within 72 ho 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(e) end menner ee stated. 296/SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Se NO 26 1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BERNARD KOZLOVS KY MAIDEN CHOICE LA 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Davideor

HYSICIAN: The law requires that the death certificate be executed within Fhours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should thit be State Dept, of Health and Mental Hypiene prior to burial, cremation, or removal.	is or item 23 shows any injury or other traumatic event, the medical examiner must be notified at once
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certif	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the ibe filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or oth

31. DATE FILEO (Month, Opy, Year) 31. DA

	ITEM: 2. PER F.H. FILM	4 G-725 7/11/9	5 t.t				95	2	1846
1	FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF I		MENTAL HYGIEN			
į.	1. DECEDENT'S NAME (First, Middle, Lest)	GRAHAM			,	2. DATE OF DEATH DO NOTH July		YEAR 3.	TIME OF DEATH
ŀ	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	4	95	ACE (State or Foreign
į	243-44-3903	1 □ M 2 □ €	64 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) 05-17-3	7	Country)	colina
. [9e. FACILITY NAME (If not institution, give at	i .			OR LOCATION OF D	EATH	9c. COU	NTY OF DEAT	
5	Bon Secours Ho	ospital		ра	ltimore			N/A	
DIRECTOR	10e. STATE 10b. COUNTY		10c. CIT	TY, TOWN OR LOCA	1177			10	d. INSIDE CITY LIMITS?
	MD . N	/A			ltimore				YES 2 NO
TONERAL	121 N. Denison	n Street			1. ZIP CODE 21229			U.S.	T COUNTRY?
5	11. MARITAL STATUS	12. WAS DECEDENT EVER I		13. WAS DEC	CENDENT OF NISPA	NIC ORIGIN? (Specify Yes	or No—	14. RACE -	American Indian,
	1 Never Married 2 I Married 3 Widowed 4 Divorced	FORCES? 1 YES			i 276 NO Speci	en, Puerto Rican, etc.) /y:	,	Specify:	Black
	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECEDENT'S (Give kind of	USUAL OCCUPATE work done during mo ise retired.)	ON ost of working	16b. KIND OF BU	SINESS/INI	DUSTRY	
1	7 th	College (1-4 or 5+)		es Asst		Healt	h		
COMPLETED	17. FATNER'S NAME (First, Middle, Last)			-	18. MOTHER'S NA	AME (First, Middle, Meiden			
	Horace Merrit	t				e Korneg			
	190. INFORMANT'S NAME (Typo/Print) Johnny Graham					Route Number, City or Tow reet Bal			21229
	20e. METHOD OF DISPOSITION PC Burlel 2 ☐ Cremetion 3 ☐ Remo	oval from State	PLACE AND DATE	OF DISPOSITION (N	ame of	OATE 20c. LO	CATION —	City or Town,	State
ŀ	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC		ledar H	ill Cen	netery	7/7 G1	enb	urnie	, MD
1	21. SIGNAL THE OF FUNERAL SERVICE LIC	Al +		22. NAME A	ND ADDRESS OF FA	172	1-27	N.Me	onroe St
	NO atha				-	s F/H Ba		•	. 21217
	IMMEDIATE CAUSE (Final	List only one cause on a	ech line.			ch as cardlec or reap	iratory ar	reat,	Approximate Interval Between Onsat and Death
CENTIFICATION	Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS)	A CONSEQUENCE O	Enfance History Henry	tion Disease				36 hours
	Disletes Mellites COMP							ERE AUTOPSY FINDINGS AILABLE PRIOR TO IMPLETION OF CAUSE OBATH?	
	DID TOBACCO USE C	ONTRIBUTE TO	CAUSE OF	DEATH Y	ES NC	Tet 1			_ 163 r _ 140
	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		28. P	LACE OF DEATH (C)	neck only one)			
	1 TYES 2 NO	1 Inpatient 2 ER/Out		4 - Nursing Hon		8 Other (Specify)			
	27. MANNER OF DEATN 1 Natural 5 Pending	(Month, Day, Year)	28b. TIN	JURY WO	IURY AT ORK? YES 2 NO	28d. DESCRIBE NOW I	NJURY OC	CURED	
	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY	/ — At home, term,			28t, LOCATION (Street		r or Rural Rout	e Number,
	4 Homicide determined	building, etc. (Spe	clfy)			City or Town, State)			
		CIAN: To the best of my know							
	29b. SIGNATURE AND TITLE OF CENTIFIER			on army operating t	29c. LICENSE NU				
	Mell no		w		2223 4		≥ 7	/4/)	onth, Day, Year)
1	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF OF	ATH (ITEM 27) (Type					. /	
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	JUL 1 1 1995	32. REGISTRAN'S SIGN	Arriall						



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	4. SOCIAL SECURITY NUMBER		E (In yes last hirthday)	IF UNDER 1 YEAR	IE IMPED 24 MDS			THPLACE (State or Foreign
	100 00 0000	The second secon		MONTHS DAYS	HOURS MIN.	(Month, Day, Year)		ntry)
			85 THS.			May 3, 19	10 Car	nada
	9e. FACILITY NAME (If not institution, give	street and number)		9b. CITY, TOWN	OR LOCATION OF OR	ATH	Oc. COUNTY OF	DEATH
E E	Croonholt Numain	o II.		0	. 1 1.		-	
ΙĶΙ	RESIDENCE OF DECEDENT	8 HOME		Gre	enberr		Prince	Georges
m	10e. STATE 10b. COUNT	ry	10c, CITY	, TOWN OR LOCA	TION			10d. INSIDE CITY
뜻	W 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1							LIMITS?
		nce Georges						1 PYES 2 NO
₹ I	106. STREET AND NUMBER			10	f. ZIP CODE		10g. CITIZEN OI	WHAT COUNTRY?
iii i	7848 Jacobs Driv	e		2	0770		U.S.	Α.
5	11. MARITAL STATUS	12. WAS DECEOENT EVE	R IN U.S. ARMED			IIC ORIGIN? (Specify Yes		CE — American Indian, ick, White, etc.
	1 Never Married 2 Merried			If yes, sp	ecity Cuban, Mexice	n, Puerto Rican, atc.)	Bit	
BY	3 Nidowed 4 Divorced	IF TES, GIVE WAN OF	UATES	1 L YES	22 XNO Specify	<i>r</i> :	l se	Mite
	15 DECEDENT'S FOR	ICATION			1.5			
쁘	(Specify only highest grad	e completed)	(Give kind of w	ork done during mo		16b. KIND OF BUS	SINESS/INDUSTRY	
Щ	Elementary/Secondary (0-12)	College (1-4 or 5+)		,				
₽	12 Yrs		Housewi	.fe		Own	Home	
0	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Surname)	
	Yudah Stiffman				Fether	Stiffmon	,	
0								
-	Sheldon A. Goldb	erg	7848 J	acobs D	rive, Gre	eenbelt, M	aryland	20770
	20a METHOD OF DISPOSITION		20b. PLACE AND DATE O	F DISPOSITION (N	ame of			
		noval from State	cemetery, crematory or other	her plece)	7/02/	L995		
			Mount Leba	non Cem	etery	Ad	elphi, N	laryland
1 1	21. SIGNATURE OF FUNESTAL SERVICE D	A I A I A		22. NAME A	ND ADDRESS OF FA	CILITY	INTERNAT I	OME THO
	1 1 Eng (1)	/\+++0	· · · · · L					
\vdash	Collara	2000	myer		ARROLL ST	C, NW, WASI	HINGTON,	DC 20012
1 1	shock or heart failure	List paly page cause pr	sed the deeth. Do no	ot enter the mo	ode of dying, auc	h as cerdiac or respi	retory arreat,	Approximate
1		Link Diny Dile Cause Di	Gacilanie.		A			interval Between Onset and Death
	diseese or condition	A - 2. C-	tim P	ne-m.	222			2 1
1 1	resulting in death)	a. / 1/0	1001	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				الملام
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Z	Commentation Non-security	b. / Verpoge	nu d	rypho	3/2~			Inuch
121		DUE TO (OR A	S A CONSEQUENCE OF):				
18	cause. Enter UNDERLYING	. Domest	19					2 40.00
E		DUE TO (OR A	S A CONSEQUENCE OF):				2 70
ΙĒΙ	resulting in death) LAST	C	11	1	1	Mai		
I W I		d. Unreve	of In a	.0.	1/100	1101111	eve,	3 year
	PART II. Other significant condition	ns contributing to death	but not resulting is	n the underlyin	a cause alven in	Part I Dan MED AN	ALITTORIEV O	AL MERE MERCAN ENGINE
🕺	0 1 1					PERFOR		46. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
181	Teant Jey	your Ti	-var-popr	1001		1 _ YES 2	ON K	COMPLETION OF CAUSE OF DEATH?
		•						1 YES 2 NO
2	DID TOBACCO USE	CONTRIBUTE TO	CAUSE OF	DEATH Y	ES I NO	950		1 123 2 110
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	25 WAS CASE DEFENDED TO MEDICAL							
O	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				LACE OF DEATH (Ch	eck only one)		
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the h	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detain		IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once
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HOSPIT	FUNER	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to Durial, cramation, or removal.	CANT
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH ANNE D. GITTLESON June 22 1995 7:50 м P 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 M 2 K F YRS. 579-24-1458 69 27 June DC Washington. 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Holy Cross Hospital Silver Spring Montgomerv 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10a. STATE Maryland 1X YES 2 □ NO Bethesda Montgomery 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5104 Acacia Avenue 20814 U.S.A. 11. MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No- RACE — American Indien, Biack, White, atc. 1 Never Married 2 X Married It yes, specify Cuben, Mexican, Puerlo Rican, etc.) 1 TYES 2 NO Specify: ВҰ Specify: 3 Widowed 4 Divorced 18e. DECEDENT'S USUAL OCCUPATION White COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INOUSTRY (Sp Montgomery County Public Elementary/Secondary (0-12) College (1-4 or 5+) 4 Yrs Teacher schools 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) F Gershon Torchinsky Bluma Rina Wolf BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Isadore I. Gittleson 5104 Acacia Avenue, Bethesda, Maryland 20814 pe 20s. METHOD OF DISPOSITION 20h PLACE AND DATE OF DISPOSITION (Name of Torah 20c. LOCATION -- City or Town, State must Removal from State 4 Donation 5 Other (Specify) Congregation Cemetery 6/23/95 Washington. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY STEIN HEBREW MEMORIAL FUNERAL HOME, INC. Torrale emiler 232 CARROLL ST 20012 NW. WASHINGTON. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one cause on each Interval Between **Onset and Death** IMMEDIATE CAUSE (Final the diseese or condition SEPSIS 7 Days event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF): traumatic PNEUMONIA CERTIFICATION 7 Days Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING other CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST Injury, or PART II. Other significent conditions contributing to deeth but not reaulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMEO? MEDICAL AVAILABLE PRIOR TO RENAL FAILURE shows any COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? DIABETES 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES PHYSICIAN: NO 13 E 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Item HOSPITAL: OTHER: 1 - YES 2 NO 1 []@npatient 2

ER/Outpatient 3

DOA me 5 - Residence 8 - Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF marked, 1 🖾 Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY --- At home, term, street, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town State) 28 is ETED.

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. OATE SIGNEO (Month, Day, Year) .D., 4609 Riverdale Road, Riverdale, D46394 July 3, 1995 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David Winn, M.D Maryland

2 MEDICAL EXAMINER: On the beels of examination and/or investigation, in my opinion, death occurs at the time, date and place, and due to the cause(s) and manner as stated.

29s. CERTIFIER
(Check only one)

1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner se stated.

19 J. F. J. F. W. · v_e; · · · · · FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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- 21	1. DECEDENT'S NAME (First	ther I	Mae Griff	Fith			•			2. DATE	DA	995	YEAR	Junknown
	4. SOCIAL SECURITY NUM 234-66-838	BER	5. SEX 1 M 2 X F	6. AGE (In yrs. le.	est birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS.	June 7. DATE O (Morth Apri	OF BIRTH , Day, Year)	1943	Country	PLACE (State or Foreig
TOR	9a. FACRITY NAME (If not institution, give street and number) Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence											ATH		
DIRECTOR	10a. STATE Maryland	10b. COUNT	ederick			Y, TOWN O								10d. INSIDE CITY LIMITS? 1 YES 2 NO
VERAL	104. STREET AND NUMBER		Rd.				10	217	_			10g. CITI	USA	HAT COUNTRY?
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BE COMPL	17. FATHER'S NAME (First, A	Middle, Last) Steven	s		00103	, 010				ME (First, M	rawfo	Surneme)		1
10	19a. INFORMANT'S NAME (alock								er, City or Town			City, Va
	1 💢 Burial 2 🗆 Cremati	20a. METHOD OF DISPOSITION 1 Disposition 3 Gramoval from State 4 Donation 5 Other (Specify) 20b. PLACEANDDATEOF OISPOSITION (Name of commetter), crematory or other place. Fair View Cemetery, crematory or other place. Fair View Cemetery											vn, State	
Ť	21. SIGNATURE OF FUNERAL	AL SERVICE LI	CENSEE Ci Fr	ields	,		leff		n Ch	apel	Funer			25414
	IMMEDIATE CAUSE (Final disease or condition resulting in death) Oue TO (OR AS A CONSEQUENCE OF): Sequentisity list conditions, if any, leeding to immediate cause. Enter UNDERLYING													
CATION	If sny, leeding to imme cause. Enter UNDERLY	idiate iNG	b					3	F	7,6	ne			
CERTIFICATION	if siny, leeding to imme cause. Enter UNDERLY CAUSE (Disease or inj that initiated events resulting in death) LAS	diate ling ury	b	O (OR AS A CONSE	QUENCE OF	F):				7/-	ine			
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	his certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	no fears 23 about interest or other bearmonals arrange the money and more more by mailting as
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exe	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fill be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation	MEDOCHANT: 16 learn 20 is married on item 22 chause and injury or other tenums

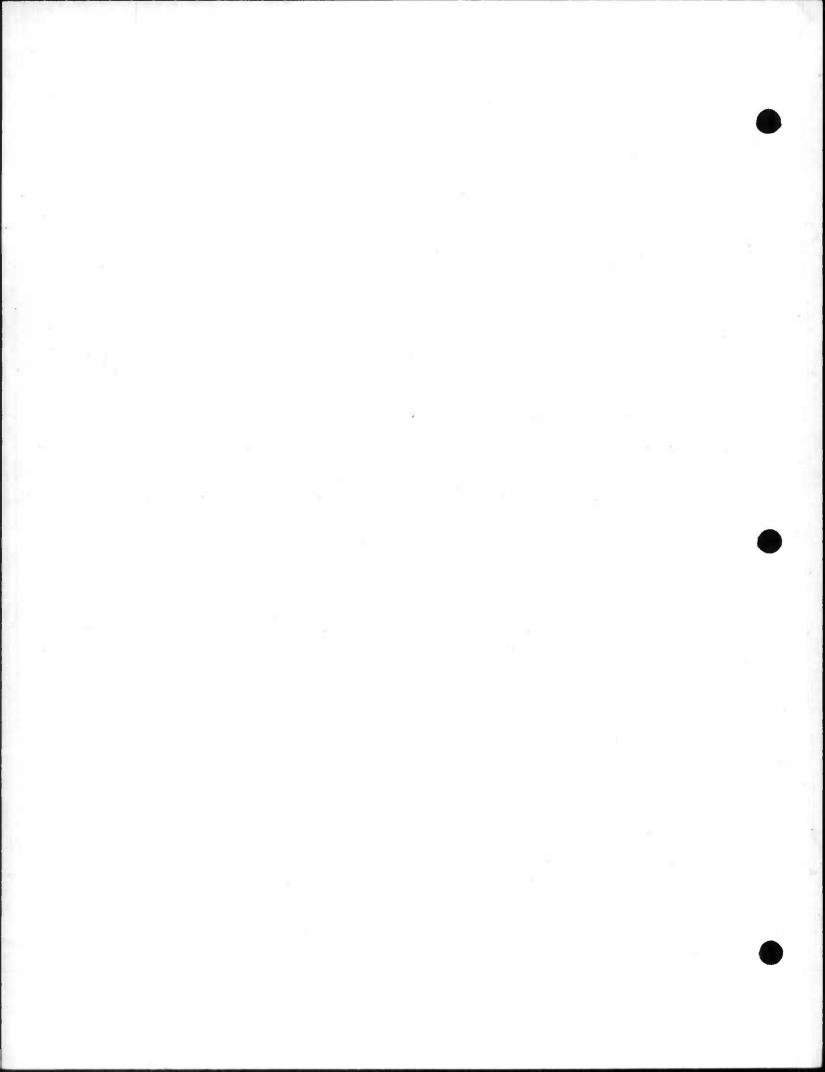
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	1 - FOR STATE REGISTRAR	STATE OF N				HEALTH AND F DEATH	MENTA	L HYGIEN REG. NO.	E		
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	4. SOCIAL SECURITY NUMBER 217 38 1056	5. SEX 1 💢 🛣 2 🗆 F	6. AGE (In yrs. 95		IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.				Country		
5	9e. FACILITY NAME (If not institution, give street and number) Anne Arundel Med. Ctr.				96. CITY, TOW Annap	OOLIS	DEATH		9c. CQU	NTY OF OE	
DIMECTOR	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY Md Anne	Arunde	1		town on Lo					T	10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER			Gan	IDITI	10f. ZIP CODE				IZEN OF WI	1 YES 2XXNO
FUNERAL	728 Md Rte 3,					21054			US	A	
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COMPLE	8th			nspec	ctor			Co.	Gov	t.	
3	17. FATHER'S NAME (First, Middle, Last)	anam C.	_			18. MOTHER'S N.			Surneme)		
1 1	John Henry Hev	ener Si				Nora					
2	190. INFORMANT'S NAME (Type/Print) Eva G. Hevener		1			et and Number or Rural					Md 21054
	20e. METHOD OF DISPOSITION 1 St Burlel 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	rel from State	cemetery, c	crematory or oth			7-1	2 20c. LO		City or Tow	
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE 1	n /	awin-		Church	ACILITY				
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	CAUSE (Disease or Injury	OUE TO	OR AS A CONS	EQUENCE OF							
	that initiated events resulting in death) LAST		On AS A CONS	EODENCE OF							
	PART ii. Other significent conditions	contributing to	death but not	reculting in	the underly	ng ceuse given in	Part i.	24e. WAS AN		24b. \	WERE AUTOPSY FINDINGS
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	1 Natural 5 Pending 2 Accident Investigation	(Month, De	ny, rear)	INJU		YORK? YES 2 NO					
	3 Suicide 8 Could not be determined	28e. PLACE OF building, o	INJURY — At t Hc. (Specify)	nome, ferm, st	reet, factory, of	lice		ATION (Street e or Town, Stelle)	nd Number	or Rural Ro	ute Number,
	29a. CERTIFIER (Check only	AN: To the best of a	my knowledge, o	death occurred	st the time, d	te end place, end due	e to the car	use(a) and man	ner es stat	ed.	
	one) 2 MEDICAL EXAMINER:										end manner as stated.
	296. SIGNATURE AND TITLE OF CENTAPIEN	MX	En	117		29c. LICENSE NU		,			Month, Day, Year)
	30. NAME AND AODRESS OF PERSON WHO	COMPLETED CAUS	E OF DEATH (IT	EM 27) (Trope 1	Print)	2416	228			110	195
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PHYSICIAN: The law requires that the death certificate be executed withly	his certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 s	with the State Dent of Health and Mental Hydiene prior to burial creat
3 PHYSICIAN: The law requires that the death certificate be executed withlive	or this certificate has been signed by the attending physician and complete	th with the State Dent of Health and Mental Heriene prior to burial creat
ING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	After this certificate has been signed by the attending physician and complete	least with the State Dent of Health and Mental Hunjene noor to hurial over
NIO	i. After this certificate has been signed by the attending physician and complete	r death with the State Dont of Health and Mental Hwiene prior to harial crear
NIO	OR. After this certificate has been signed by the attending physician and complete	the death with the State Dont of Health and Mental Husians prior to harial creat
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NIO	IRECTOR: After this certificate has been signed by the attending physician and complete	New other death with the State Dent of Health and Mental Hydiene prior to burial over
Z	DIRECTOR: After this certificate has been signed by the attending physician and complete	hours after death with the State Dont of Health and Mental Hydiene prior to burial cre-
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NIO	IERAL DIRECTOR. After this certificate has been signed by the attending physician and complete	In 7 hours after death with the State Dent of Health and Mental Hydiene noor to hurial crea
NIO	UNERAL DIRECTOR. After this certificate has been signed by the attending physician and complete	office 7 hours after death with the State Dant of Health and Mental Hunjene prior to huntal pre-
NIO	E FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and complete	within 7 hours after death with the State Dent of Health and Mental Horizon prior to burial cres
NIO	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete	a high within 7 hours after death with the State Dent of Health and Mental Husiene prior to hurial cre-

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO.									
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF	DEATH			TIME OF DEATH
1		Joseph H. Hall			June 13, 19			, 19	95	8:15 A M
	4. SOCIAL SECURITY NUMBER				F UNDER 24 HRS.	7. DATE OF (Month, D	BIRTH By Year)	6.	BIRTHPLA Country)	NCE (State or Foreign
	216-01-7244 9e. FACILITY NAME (If not institution, give s	1 🔀 M 2 🗆 F	92 YRS.			Mar 2		-		Md
Œ				b. CITY, TOWN OR		EATH		9c. COUNTY		н
DIRECTOR	Inns of Everg	reen Facili	LTY .	Baltimo	ore			111	/A	
R	10e. STATE 10b. COUNT	N/A		TOWN OR LOCATION	N				1000	d. INSIDE CITY LIMITS?
	Md	N/ A	Bal	timore						YES 2 NO
FUNERAL	4411 Cedar Gard	don Poad		101. ZIP CODE 21229				10g. CITIZEN OF WHAT COUNTRY?		
JNE	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	V U.S. ARMED		DENT OF HISPAN	AIC OBIGINS (6	manifu Van a	U		American Indian,
F	1 Never Married 2 Merried	FORCES? 1 YES	2 PNO	If yes, speci	fy Cuben, Mexica	n, Puerto Rica	n, atc.)	* NO _ 14.	Black, W	hite, etc.
) BY	3 Widowed 4 Divorced			1	A Specif	,. 			Specify:	Black
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S US	k done durina most d	of working	16b. KII	ND OF BUSIN	NESS/INDUST	RY	
PLE	Elementary/Secondary (0-12) UNKNOWN	College (1-4 or 5+)	Labore:				laugi	hter	НОШ	50
OMI	17. FATHER'S NAME (First, Middle, Last)	TIKITOWIT	nabole.		8. MOTHER'S NA			_	1100	26
BE C	Walter Hall			1	Jnknown	me (rirat, miou	re, merceri su	arriame)		- 1
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AC	ORESS (Street and		Route Number,	City or Town,	State, Zip Coo	de)	03000
ř	Garland T. Day	vis		Cedar			d Ba	altim	iore	,21229 Ma
	20e. METHOD OF DISPOSITION XIXBurlel 2 Cremetion 3 Ram	coval from State Corr	PLACE AND DATE OF C	DISPOSITION (Name	ol	DATE	20c. LOCA	TION — City	or Town,	State
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FURERAL SERVICE LICE	F	cing Mei				5 Rai	ndall	sto	wn, Md
	21. SIGNATURE OF POPERAL SERVICE LIC	ENSBE			ADDRESS OF FA					
	4 priles	Coron		4300	Wahas	sh Av	enue	Balt	0,	Md 21215
	23. PART I. Enter the diseases, or of ahock, or heart fellure.	complications that caused List only one cause on e	the death. Do not sch iins.	enter the mode	of dying, auci	h as cardiac	or reapire	tory arrest		Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition	A. 0-		welv						Onset and Death
	resulting in death)	· Colo		mey						
-	DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate OUE TO (OR AS A CONSEQUENCE OF):									
CA	cause. Enter UNDERLYING CAUSE (Disease or injury	c								
1	that initiated events resulting in desth) LAST	DUE TO (OR AS A	CONSEQUENCE OF):							
Ä	Total and a south of the south	d								
	PART II. Other significant condition	a contributing to death b	ut not resulting in t	he underlying c	ause given in	Part i. 24	. WAS AN AL			RE AUTOPSY FINDINGS
MEDICAL	37	oke					PERFORM	/	COI	MPLETION OF CAUSE
ME										DEATH? YES 2 NO
ä	DID TOBACCO USE CONTI				UNCERTAIN	1 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	Check only one)						
1YS	1 VES 2 W NO	1 Inpatient 2 ER/Outp	atient 3 DOA 4	Nursing Home						
	1 Natural 5 Pending	(Month, Day, Year)	28b. TIME O	r WORK		28d. OESCRI	BE HOW INJ	URY OCCURE	D	
BY	2 Accident Investigation 3 Suicide & Could not be	28a. PLACE OF INJURY	At home, farm, stree		2 110	28f. LOCATIO	N (Street and	t Number or B	turni Acute	Number
Ä	4 Homicide detarmined	City of Tourn State)								
PE	290. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of my knowle	edgs, death occurred a	t the time, date and	d place, and due	to the causels	and manne	y an eteted		
COMPLETED		R: On the besis of examination							uee(a) and	f manner es stated.
	296. SIGNATURE AND TITLE OF CENTIFIER	10,		25	C. LICENSE NUM	BER	_ 2	9d. DATE_SIG	EO (MO	nth, Day, Yearl
TO BE		Juny/	M	V	035	683		1 6	119	195
Ĕ	30. HAME AND ADDRESS OF PERSON WIN	O COMPLETED CAUSE OF DE	THE TEM 27) (Type, And	10	Ci	1.0	ilm	L	0 1	P
	SHUHIUKHU	H HOLL	verge	v U	- 80	nac	NOS	me	~ '	
	JUL 1 1 1995	Le d'indicar hard	Call				PV	, ph	> 1	uw



DIVISION OF VITAL RECORDS, P.O. BOX 68760

6 9	**************************************	IT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDIN	TO THE FUNERAL DIRECTOR: After this or be filed within 72 hours after death with	IMPORTANT: If item 28 is market

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	IEALTH AND	MENTAL HYGIEN			
	1. DECEOENT'S NAME (First, Middle, Last)					2. DATE OF DEATH 3. TIME OF DEATH			
	MARGARET	HUEY				Jul 5 1995 YEAR 2:23 am			2:23 am w
	4. SOCIAL SECURITY NUMBER			IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHI	PLACE (State or Foreign
	215-22-4258 9e. FACILITY NAME (If not institution, give st	1 M 2 X F 90	YAS.	96. CITY, TOWN O	HOURS MIN.	3-22-19	905	MAR	YLAND
DIRECTOR	Saint Joseph Medic	si Center			on, Maryl			ltimo	
EC	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	TION				10d, INSIDE CITY
DIF	MARYLAND BALT	IMORE	TO	WSON					LIMITS?
FUNERAL	10% STREET AND NUMBER 800 SOUTHERLY	RD.		101. ZIP CODE 21204			10g. CITIZEN OF WHAT C		
	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	If yes, sp	ENDENT OF HISPA ecify Cuben, Mexico 2 NO Specie	nn, Puerto Rican, atc.)		4. RACE — American Indien, Black, White, etc. Specify:	
D BY	3 Wildowed 4 Divorced	1						Opto	WHITE
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	ATION completed)	(Give kind of wo	rk done during mo	ON st of working	16b, KIND OF BU	SINESS/INDU	ISTRY	
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	HOUSEW			номі	EMAKE	D	
MO	17. FATHER'S NAME (First, Middle, Last)		посын	1111	16. MOTHER'S NA	AME (First, Middle, Maiden		10	
	TALBOTT DENME	AD				ARET MORE			
) BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street e	nd Number or Rural	Route Number, City or Tow	n, Stete, Zip (Code)	
5	TALBOTT HUEY		758 B	ERKSHI	RE LN.	EAST LAN	SING	,MI	CHIGAN488
	20a_METHOD OF DISPOSITION 1		PLACE AND DATE OF DELETY CREMENTS OF OTHE EEN MOU				CATION — C		
	21. SIGNATURE OF FUNERAL SERVICE LICE		<u> </u>	22. NAME AN	D ADDRESS OF FA	CILITY			
	*William K	· Pavis III	_	4905	YORK 1	ENKINS & RD. BALTO	. MD	. 2	
	23. PART I. Entar the diseases, or contains abook, or heart failure. L	omplications that caused	tha death. Do no	t anter tha mo	da of dying, suc	h as cardiac or resp	iratory arre	at,	Approximata Interval Between
	IMMEDIATE CAUSE (Final	PROBABLE C		SCULAR	ACCIDEN	т			Onset and Death
	War to sales i		CONSEQUENCE OF):						
NO	Sequentially list conditions, HYPERTENTION								
ATI	DUE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):						
E	resulting in death) LAST								Ì
	DATE II OAL - I - MI - A - A III								+
SAL	PART II. Other algorificant conditions				cause given in	Part i. 24s. WAS AN PERFOR			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDIC	CHRONIC OBSTRU			ASE		1 _ YES 2	NO		OF DEATH?
	GASTROESOPHAGE DID TOBACCO USE CONTR				LINIGEDIA				1 TYES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH		UNCERTAI	N L			
PHYSICIAN:		HOSPITAL:		THER:	s □ Residence	6 Other (Specify)			
¥	27. MANNER OF DEATH	26e. DATE OF INJURY (Month, Day, Year)	26b. TIME	OF 26c. INJ	URY AT	28d. DESCRIBE HOW I	NJURY OCCU	IRED	
ВУ	1 Natural 5 Pending	(Month, Day, Year)	INJUE		RK? 'ES 2 NO				
	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, tectory, office City or Town, Steet) 28e. PLACE OF INJURY — At home, farm, street, tectory, office City or Town, Steet)						oute Number,		
E	290. CERTIFIER 1 CERTIFYING PHYSIC	TAN: To the heat of my trans-	ladge death account 1	at the time of the	ing agent and a		v s v Asmer		
COMPLETED		EAN: To the best of my knowl R: On the basie of exemination							end manner as stated,
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI				Month, Day, Year)
BE	C DEN	w w	3		D 37254		▶ 3	-/5	195
5	30. NAME AND AGORESS OF PERSON WHO	COMPLETED CAUSE OF OE						1 1	, , , -
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN		Find Wilmid	·	LIEUT.			
	JUL 11 1995	eva a we carrow							

and the factor of the factor o

3. TIME OF DEATH

10d. INSIDE CITY LIMITS?

RACE — American Indian, Black, White, etc.

1 YES 2 NO

8. BIRTHPLACE (State or Foreign Country)

9c. COUNTY OF DEATH

HARFORD

10g. CITIZEN OF WHAT COUNTRY?

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3 Suicide

4 Homicide

29b. SIGNATURE AND TITLE OF CERT

JAMES 31. DATE FILED (Month, Day, Year)
JUL 11 1995

29a. CERTIFIER (Check only one)

6 Could not be

COMPLETED

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9

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 CERTIFICATE OF DEATH DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH AYMano HOLI 29 JUNE 5. SEX 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) NOV-619 IF UNDER 1 YEAR IF UNDER 24 HRS. YRS. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR PT-A IMORY LANS AGINGDON 10b. COUNTY 10c. CITY, TOWN OR LOCATION HARFORD ABINGDON permit. FUNERAL 10e STREET AND NUMBER 101. ZIP CODE funeral director, page 5 should be detached for use as the burial-transit 3813 APT IMORY LANK POOIS retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yea, specify Cuben, Maxican, Puerto Rican, etc.)
1 YES NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only high College (1-4 or 5+) TRUCK DRIVER 37RS Ben FRANKLIN STORIE once. 17. FATHER'S NAME (First, Middle, Last) ALBERT BE notified 19a. INFORMANT'S NAME (Type/Print 19b 2 SHARON 2 99 20a. METHOD OF DISPOSITION
1 Description Burlel 2 Cremellon 3 Description Burlel (Specify) Раде 6 тау 20b. PLACEA must cometery, crai 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner Nano completely filled in by the medicai 23. PART I. Enter the diseases, or complications that caused the de shock, or heart failure. List only one cause on each line 6 IMMEDIATE CAUSE (Final cremation. the disesse or condition an event, resulting in desth) DUE TO (OR AS A CONSEC r signed by the attending physician and con Health and Mental Hygiene prior to burial. HOS traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEC If sny, leading to immediate cause. Enter UNDERLYING death certificate be CAUSE (Disesse or Injury other DUE TO (OR AS A CONSEQ that initiated events resulting in death) LAST 6 PART II. Other algnificant conditions contributing to death but not re requires that the PHYSICIAN: MEDICAL any shows has been s DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEAT OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? item TO THE HOSPITAL OR ATTENDING PHYSICIAN: The TO THE FUNERAL DIRECTOR: After this certificate is be filed within 72 hours after death with the State IMPORTANT: If Item 28 is marked, or Item HOSPITAL: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 1 Natural 8 2 Accident

26a. PLACE OF INJURY — Al hor building, etc. (Specify)

32. REGISTRAR'S SONATURE

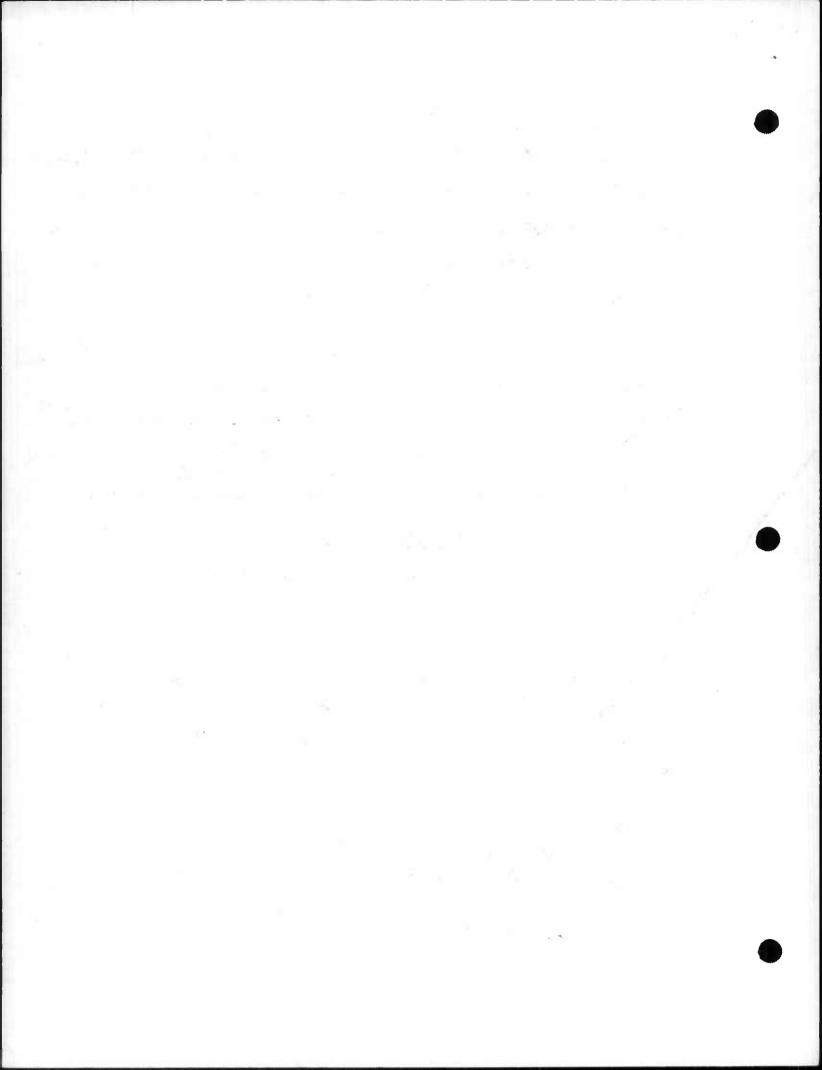
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1 CERTIFYING PHYSICIAN: To the bast of my knowledge, dea

2 MEDICAL EXAMINER: On the basis of an

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM

			VALL	010162
1	8. MOTHER'S NAME (First,	Middle, Maiden Sumame)		
	GRACI	HARI		
MAILING ADDRESS (Street and	Number or Rural Route Num	BUALR C) ARY	21015 -A00
ND DATE OF DISPOSITION (Name natory or other place)		TE 20c. LOCATION — City	or Town,	
1 ICOUT LIST	JHICKA 0	2 BALLING	RE!	JARY LAGO
SVANS 3050	FUNERAL C	HAPIL - BY	LA:	1. Paloso
th. Do not enter the mode	of dying, such ae cer	diec or reapiretory arrest	,	Approximate Interval Batween Onset and Death
UENCE OF): Value	replace	emal		
UENCE OF):	0			
UENCE OF):				
sulting in the underlying c	ause given in Part i.	24a. WAS AN AUTOPSY PERFORMED?		RE AUTOPSY FINDINGS
		1 TES THE NO	OF:	ILABLE PRIOR TO IPLETION OF CAUSE DEATH?
H YES 🗆 NO 🍯	UNCERTAIN		1	YES 2 NO
OF DEATH (Check only one) OTHER:				
	5-10 Residence 6 - Other	er (Specify)		
28b. TIME OF INJURY WORK M 1 YES	?	SCRIBE HOW INJURY OCCUR	ED	
e, farm, street, factory, offica	261, LOC City	CATION (Street and Number or Foun, State)	Rural Route	Number,
n occurred at the time, data an			Buse(a) and	manner as stated.
	H 18792	9/20 £ 29d. DATE SI		
27) (Type, Print)	C-11 C110	0) 5.0.		7,110
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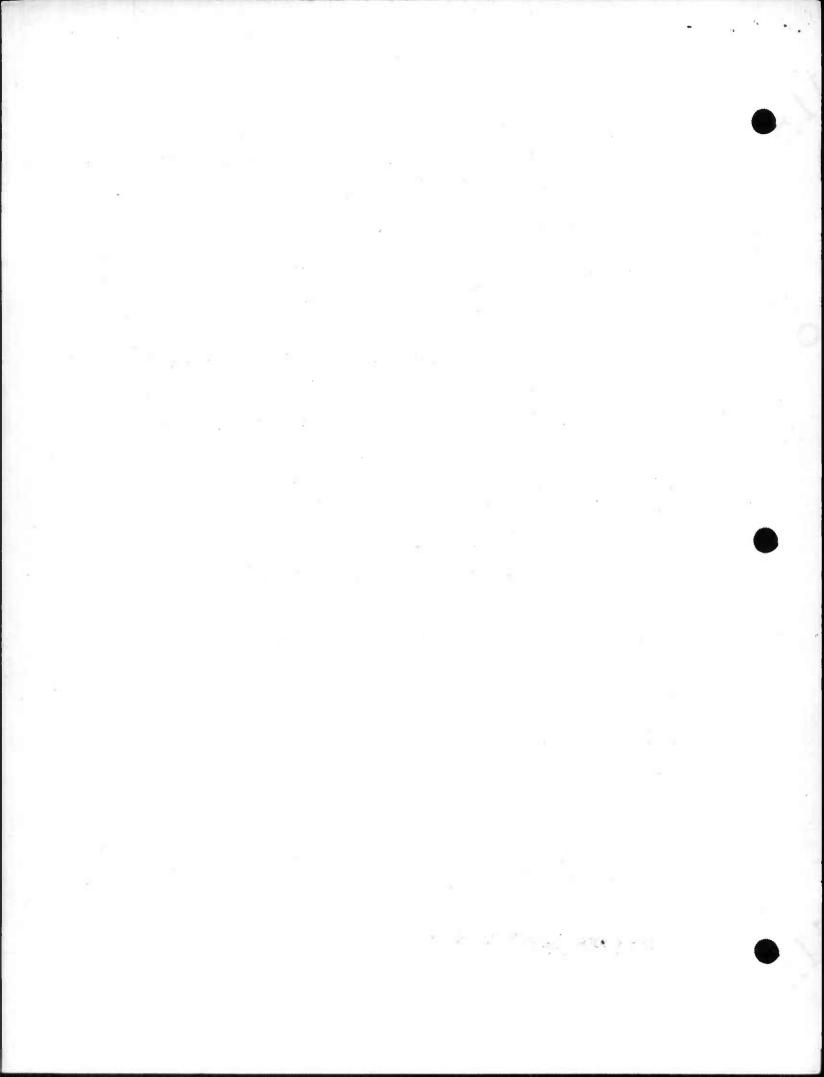
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his certificate has been si	with the State Dept. of rie	
offer this certificate has been si	eath with the State Dept. of Me	
OR: After this certificate has been si	tier death with the State Dept. of Me	
IRECTOR: After this certificate has been si	HUTS ARE DEATH WITH THE STATE DEDI. OF ME	
AL DIRECTOR: After this certificate has been si	/2 hours after death with the State Dept. of He	
	med by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 sho	UNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 sho right 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

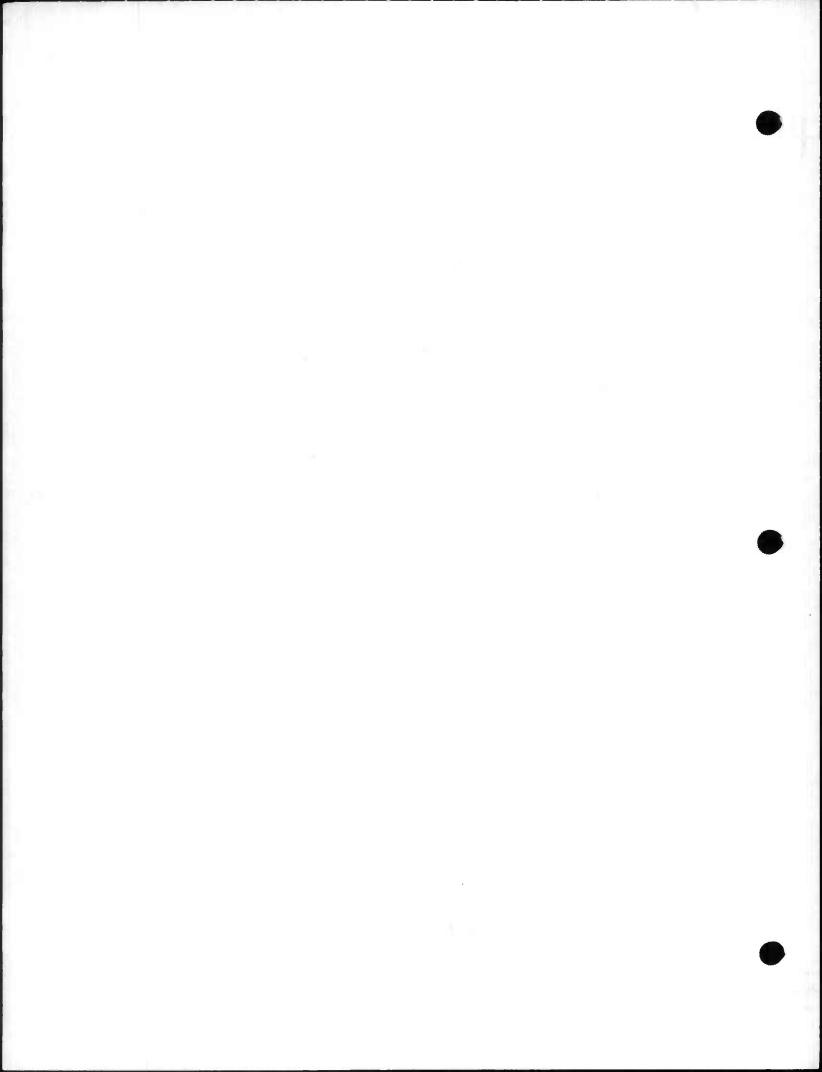
REG. NO.

	_	REG. NO.
- 1		1. DECEDENT'S NAME (First, Middle, Light) 2. DATE OF DEATH MONITOR 3. THE STOCK H MONITOR OF DEATH O
-		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. less birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BATTH 8. BIRTHDE ACE (State or Foreign
		1 DAY 2 F VRS MONTHS DAYS HOURS MIN. (Month, Day, Year)
		96. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH
	H	GBMC- Emergency Coops. Truscan MD RUTO.
	5	RESIDENCE OF DECEDENT
- [DIRECTOR	10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS?
		100. STREET AND NUMBER 101. ZIP CODE 102. CITIZEN OF WHAT COUNTRY?
	FUNERAL	109. CITIZEN OF WHAT COUNTRY? 109. CITIZEN OF WHAT COUNTRY? 109. C. A.
	3	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Year of No. 14 BACF - American Indian
-		1 Never Married 2 Merried FORCES? 1 YES 2 NO If yes, specify Cuben, Mexican, Puerto Rican, atc.) Black, White, atc.
ĺ	D BY	WHITE
	TED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life, Do NOT serting) 16b. KIND OF BUSINESS/INDUSTRY
	COMPLET	Elementary/secondary (0-12) College (1-4 or 5 +)
once.	8 0	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)
76	BE C	WILLARD C. HOLT. SR LOWICE H. MARSIK
notified	OB	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rugal Route Number, City or Town, State, Zip Code)
be no	-	Ams MARIE HOLL HISRON LOURT HARKVILLS, MARYLAND 21234
must b		20a, METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION Name of 20b. PLACE AND DATE OF DISPOSITION Name of 20c. LOCATION — City or Town, State 20c. METHOD OF DISPOSITION Name of 20c. METHOD OF DISPOSITION 20c. METHOD OF DISPOSITION 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town
E La		4 Donation 5 Other (Specify) JARRISON FORWY VILLARS 95 GARRISON JARYLAND
amin		WANT AND ADDRESS OF PACIFIC PEROPESS
al ex		1 Xous Ar Travo, 1 8800 HARFORD ROAD-PARKVILLE
medical examiner		23. PART I. Enter the diseases, or compilections that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heert fellure. List only ope cause on each line.
he m		IMMEDIATE CAUSE (Finel
or other traumatic event, the		disease or condition resulting in death) s. Accuracy Company Charles on the consequence of the consequence o
C GV	-	- (Pagaza) Cul Distanti Nissan
mat	CERTIFICATION	Sequentielly list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):
tra	3	cause, Enter UNDERLYING CAUSE (Disease or Injury
othe		thet initieted events DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST
	5	d
any injury,		PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PINOINGS PERFORMED? AMALABLE PRIOR TO
	DICAL	PERFORMED? AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
hows	ME	1 _ YES 2 _ NO
23 \$	ÿ	
tem	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINED OTHER: 26. PLACE OF DEATH (Check only one)
0	17S	1 PTES 2 NO 1 Inpatient 2 PER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 286. DATE OF INJURY 286. TIME OF 286. INJURY AT 286. DESCRIBE HOW INJURY OCCURED
is marked, or item 23 sho	PHY	1 Natural 5 Pending (Month, Day, Year) INJURY WORK?
s ma	ВУ	2 Accident 3 Suicide 28. PLACE OF INJURY — At home, larm, street, lactory, office 28I, LOCATION (Street and Number or Bural Brute Number)
887	TED	S Could not be datermined building, stc. (Specify)
item	PLET	29e. CERTIFIER (Check only 1 CERTIEVING PHYSICIAN: To the best of my knowledge, death occurred at the lime, date and piece, and due to the cause(e) and menner as attend.
MPORTANT: If item	COMPL	one) 2 MEDICAL EXAMINER: On the besis of exemination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(e) and manner as stated.
RTA	ш	296. SIGNATORE AUSTITLE OF CONTINUE 296. DATE SIGNED/Morth Ay, 1967)
IMPC	10 B	Melest Donnelley 1) OCMB 17/8/95
	F	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
	1	MOYES FOUD QUELLINA-11/ ADMINET HILL BOTTOMENTE
		31. DATE FILED (Month, Day, 198) 32 Marie 1984
L		

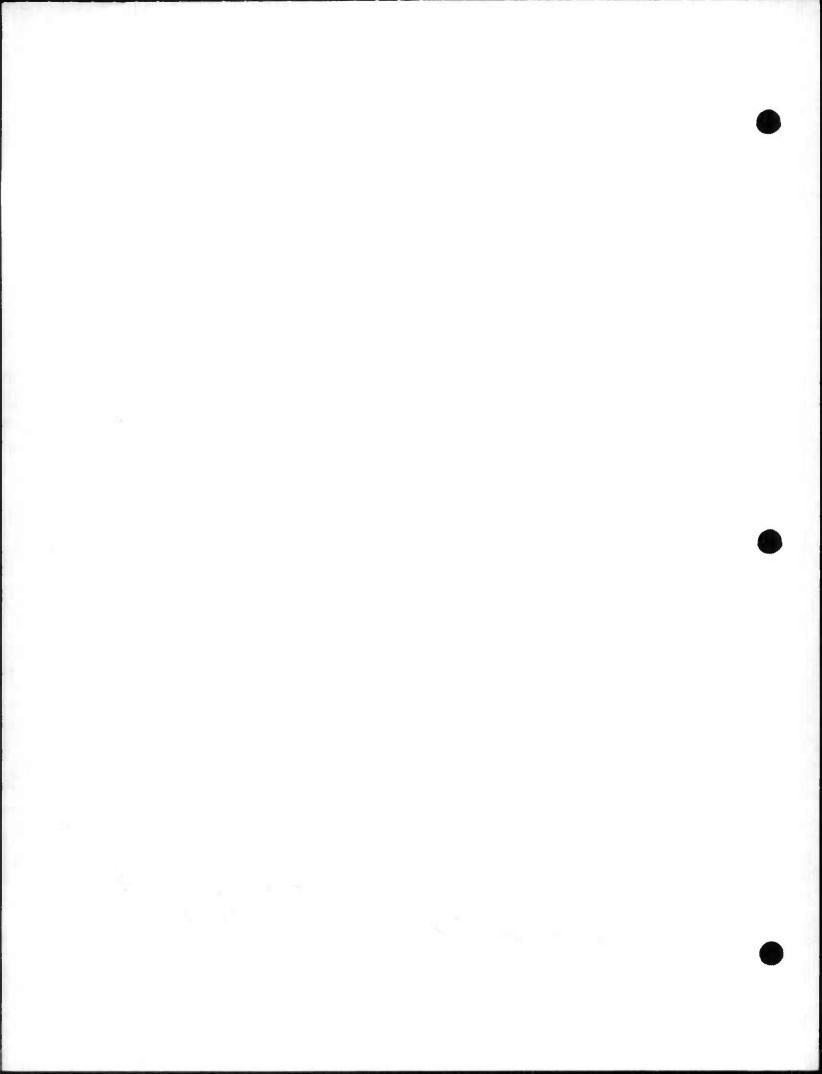


BALTIMORE, MARYLAND 21215-0020	A hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	e medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funer be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARY		RTMENT OF I			YGIENE EG. NO.			
	1. DECEOENT'S NAME (First, Middle, Last) GLORRAINE	F.	HARRI			2. DATE OF C	DEATH	995	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGI	E (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF B	IRTN Vanct	8. BIRTN Country	PLACE (State or Foreign	
	070-60-6240 Se. FACILITY NAME (If not institution, give str	1 M 2 KF	34 YRS.	9b, CITY, TOWN	OR LOCATION OF D	Jan.	7, 1961	West	Indies	
TOR	Stella Maris H	ospice		Tou				altin		
DIRECTOR	10e. STATE 10b. COUNTY		10c. CI	TY, TOWN OR LOCA				Т	10d. INSIDE CITY LIMITS?	
	Md.				timore		10a. C	TIZEN OF W	1 X YES 2 NO	
FUNERAL	215 Atholgate	Lane Apt	. B		21229		109.00	us		
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES	2 NO	II yes, sp	ENDENT OF NISPA ecity Cuban, Mexico 2 XNO Specia	an, Puerlo Rican	pecify Yea or No-	14. RACE Black Specifi	- American Indian, White, etc.	
COMPLETED	15. DECEDENT'S EDUCI. (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5 +)		S USUAL OCCUPATI I work done during me use retired.)		16b. KINI	O OF BUSINESS/IN	IOUSTRY	black	
MPL	12		Direct	: Care As					Hospital	
	17. FATNER'S NAME (First, Middle, Last) Evered J. Fontai	14.0					, Maiden Surname)			
BE	19a. INFORMANT'S NAME (Type/Print)	rie	195 MAILIN	G AODRESS (Street		ie S. E		Zin Codel		
임	Charlene Winters			tholgate					ld. 21229	
	20e. METHOD OF DISPOSITION 1 W Buriel 2 Cremetion 3 Remove 4 Donation 6 Other (Specify)	ral from State	Db. PLACE AND DATE metery, cremetory or WANEY V	PLACE AND DATE OF DISPOSITION (Name of OATE 120c. LOCATION — City or Town, State of Cockeys ville, Md.						
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE		22. NAME AND AGORESS OF FACILITY 11824 Reis						
	C. Buan Towell Eline Funeral Home Reisterstown,									
	23. PART i. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval one cause on each line. Approximate CAUSE (Finei disease or condition as AIDS									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF):									
PHYSICIAN: MEDICAL C	PERFORMED?								WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH?	
Σ ::	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN								1 TES 2 NO	
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		ATH (Check only one) OTHER:						
ĪŠ	1 YES 2 NO	1 Inputient 2 ER/Ou		4 - Nursing Non	e 5 🗆 Residence	6 Other (Spe	- 110	SPICE		
BY P	Notetural 5 Pending	(Month, Day, Year)		IJURY WO	RK?	28d, DEȘCRIBE HOW INJURY OCCURED				
	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)								oute Number,	
COMPLETED	29e. CERTIFIER (Check only one) CERTIFYING PNYSICI	AN: To the best of my kno							and manner as stated,	
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIED. 296. LICENSE NUMBER 296. DATE SIGNED (Mor									
	30. NAME AND ADDRESS OF PERSON WHO DR. KENDALL FAULK 31. DATE FILED (Month, Day than)		TILANEY V	e, Prim) VALLEY RO	AD TOWS	ON, MD	21204			
	JIII 11 1995 Fall	N SU SUNDANCE POR								



		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR CERTIF	TMENT OF I	HEALTH AND		YGIENE EG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last) CLARENCE	, ,				2. DATE OF SMONTH	DEATH DAY	YEAR 9	3. TIME OF DEATH
pin		4. SOCIAL SECURITY NUMBER 219 - 40-0602	1 M 2 D F 40	yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF E (Month, De	1/1945	Country) Ma	ryland
1, 2, 3 should	стоя	99. FACILITY NAME (If not institution, give a	treet and number)			timore	DEATH	9c. COU	n/a	
Pages	DIRE	Maryland 10b. COUNT	n/a		, TOWN OR LOCA				- 1	10d. INSIDE CITY LIMITS? 1 YES 2 \(\text{NO}\) NO
nsit permit.	FUNERAL	3016 Brighton S	treat		10	21216		10g. CIT	USA	HAT COUNTRY?
215-0020 attending physician. use as the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U. FORCES? 1 YES IF YES, GIVE WAR OR DATE	2 XNO	If yes, s	CENDENT OF HISPA pecify Cuben, Mexic S 2 NO Speci	en, Puerto Ricar	pecify Yes or No— , etc.)	14. RACE	— American Indian, White, atc.
	ETED	15. DECEDENT'S EDU (Specify only highest grade	completed)	IGA. DECEDENT'S (Give kind of w life. Do NOT us	vork done during m	ION ost of working	16b. KIN	D OF BUSINESS/IN	DUSTRY	Bl.ack
ND 2 hospital ached to	COMPLE	Elementary/Secondary (0-12) 11th Grade	College (1-4 or 5+)		ant Man	_		quor Sto	re	
ALA be del	ш	17. FATHER'S NAME (First, Middle, Last) Clarence J. Hamm,	Sr.			Maybel		e, Maiden Sumeme)		
MAR retained 5 should notified	TO B	190. INFORMANT'S NAME (Type/Print) Hattie M. Hamm				and Number or Rural	Route Number, C	ity or Town, State, Zi		
m A S S		20s METHOD OF DISPOSITION	200. P	LACE AND DATE O	F DISPOSITION /N	Blvd.	Apt A-3	Baltin 20c. LOCATION —		
Page I dire		4 Donation 5 Distartispecity)	Mt/	Zion Ce	meterv	ND ADDRESS OF F	1 7	Baltim	ore,	Maryland
SALT death. he funera al.	Ц	· true!	M. Am	th	2501 (Balti	Gwynns F more, MD	alls Pa 21216	ter Fune rkway	ral H	lomes, Inc
2 = 5 €		IMMEDIATE CAUSE (Final disease or condition	complications that coused to List only one cause on each of the CERBRA	th line.			ch as cardiac	or reapiratory ar	reat,	Approximate interval Between Onset and Death
ed within completely al, cremati		resulting in death)	DUE TO (OR AS A C	ONSEQUENCE OF):					1 day
be executed cian and con or to burial, aurmatic or	ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A C			MUCH:	126			I week
S, P.O. BO death certificate be a attending physicia ental Hygiene prior iry, or other trau	ERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):							
0 6 5 5	CAL C	PART II. Other significant condition	s contributing to desth but	not reaulting in	n the undariyin	g cause given in		WAS AN AUTOPSY PERFORMED?	A	WERE AUTOPSY FINDINGS
FECORD requires that the been signed by the conference of Health and Insulative shows any Inj	MEDIC						1	YES 2 NO	٥	COMPLETION OF CAUSE OF DEATH?
Sept S	AN:	DID TOBACCO USE CONTI		DEATH YE			NØ			
SICIAN: The certificate he the State he to the State he to the state he to the	PHYSICIAN:	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpati	lent 3 DOA	OTHER: 4 - Nursing Hon	ne 5 🗆 Residence	6 Other (Spe	ocify)		
NG PHYSIG fer this ce eath with t	ву Рн	27. MANNER OF DEATH 1 K Natural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	URY WO	DURY AT DRK? YES 2 NO	28d. DESCRIE	E HOW INJURY OC	CURED	
TTENDI TTOR: A after da		2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — building, etc. (Specify)	28e. PLACE OF (NJURY — At home, farm, street, factory, office building, etc. (Specify)			281. LOCATION City or Tox	(Street and Number vn, State)	or Rural Rou	ste Number,
7 12 -	COMPLETED		CIAN: To the best of my knowled P: On the basis of examination e							and manner se stated,
To the Hospita To the Funera De filed within 7	TO BE	290. SIGNATURE AND TITLE OF SERTIFIER		22	2	29c, LICENSE NU	MBER 294	29d. DAT	E SIGNED (A	Month, Day, Year)
5		30. NAME AND ADDRESS OF PERSON WHILL LAW RENCE S.	COMPLETED CAUSE OF DEATH CHUN 22 AEGISTABLE COMP	H (ITEM 27) (Type,	Print) -REENE	ST. ,	ROOM S	72D, B+	4170	HD 21201
		31. DATE BILED (Month, Day, Your) 1995	The Steer of	Redall						

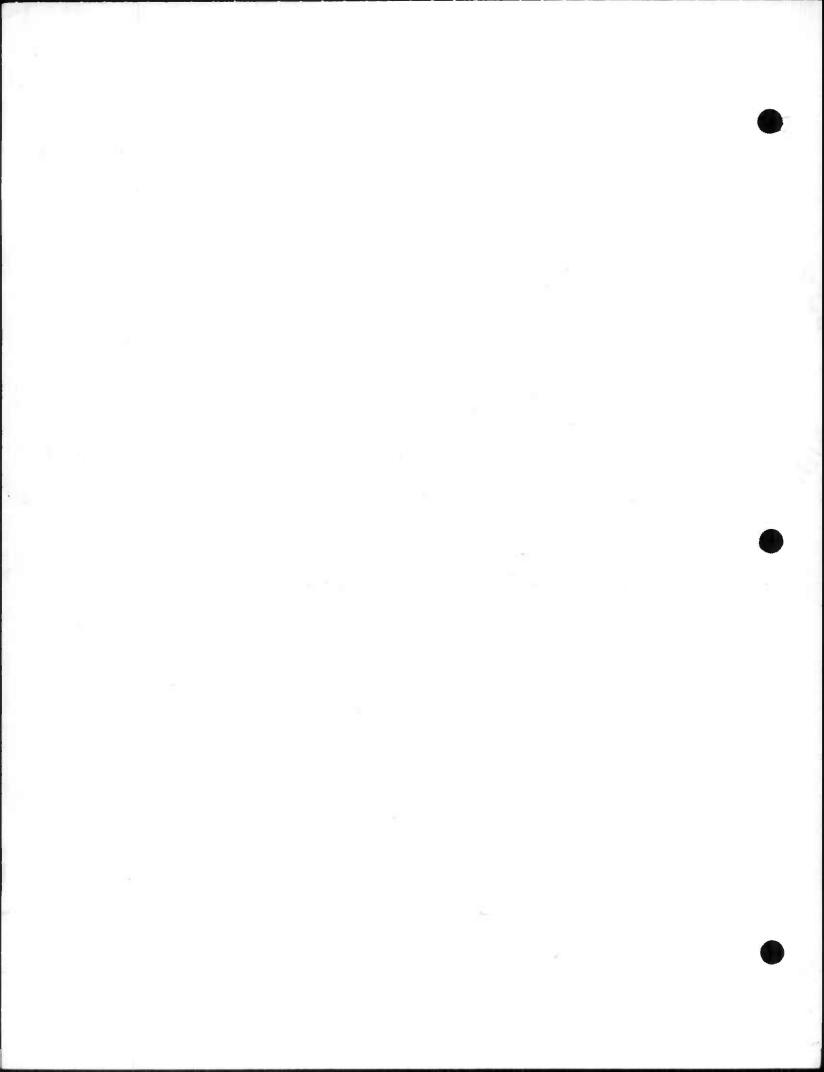


DIVISION OF VITAL RECORDS, P.O. BOX 68760

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HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. within 72 hours after death with the State Dept. of Health and Mental Hydiene prior to burial, cremation, or removal.	

								9	3 20031
		1 - STATE REGISTRAR	STATE OF MARYLAN	D / DEPAR	TMENT OF I	HEALTH AND			
		1. DECEDENT'S NAME (First, Middle, Last)	TE	VKI	NS	DEATH	2. DATE OF DEA	I. NO.	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In vi	s. last birthday)	IF UNDER 1 YEAR		(hel	469	5 11,50/4
10		258-98-3150	1 M 2 D F 37	YRS.	MONTHS DAYS	HOURS MIN.	7. DATE OF BIRT	1957 1957	BIRTHPLACE (State or Foreign Country)
3 should	~	9a. FACILITY NAME (If not institution, give st				OR LOCATION OF D		9c. COUNT	Y OF MEATH
2	DIRECTOR	Union Memoria	al Hospital		Bal	timore	City	/	V/A
ges 1	EC	10a. STATE 10b. COUNTY	1.1.	10c, CIT	Y, TOWN OR LOCA	TION		7	10d. INSIDE CITY
permit. Pages 1,		Mary and	V/A	1B	altir	nore			1 D YES 2 NO
. isi	FUNERAL	210 N. Care	v St.		10	2 12	73	16g. CITIZE	N OF WHAT COUNTRY?
physician. burial-transit	J.	11. MARITAL STATUS	2. WAS DECEDENT EVER IN U.S	S. ARMED	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Spec	Ify Yes or No- 14	4. RACE — American Indian, Black, White, atc.
	BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DATES			ecity Cuben, Maxic 2 D NO Speci		ic.)	Black
r attending use as the	E	15. DECEDENT'S EDUC (Specify only highest grade	CATION 16.	(Give kind of a	USUAL OCCUPATION	ON ost of working	16b. KIND (F BUSINESS/INDUS	STRY
0 _	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life. Do NOT us	e retired.)	or or working			
the hospital detached fo	ON	17. FATHER'S NAME (First, Middle, Last)	111			18. MOTHER'S N	AME (First, Middle, A	felden Sumame)	
# E &	BE (Samuel Ja	enkins			Mi	drea	Da	VIS
	2	GEORGE GYO	int Jr	2/0	ADDRESS (Street of	PV ST	Poute Number, City	or Jown, State, Zip Co	1. 21223
may be		20a. METHOD OF BISPOSITION 1 M Buriel 2 Cremetion 3 Remo	neal from State	CEANDDATE	OF DISPOSITION (No	ame d	DATE, 2	CLOCATION - CIT	y or Town, State
age 6 ma director, p		4 Donation 5 Other (Specify)		A Porybro	1142		7/13/95/	391to.	Co. Md.
death. Page 6 may be e funeral director, page L. examiner must be		21. SIGNATURE OF FUNERAL SERVICE LIG	P.D.	/	JOSE	ND ADDRESS OF FA	RUSS	Fun	eral Home
0 - 0		23. PART I Enter the discesse, or c	omoliceflens that caused th	Adath Dor	222	2 W.No	rth Av	le Bal	to. Md. 21216
hours or n		shock, or neart reliure.	ist only one ceuse on eech	line.	ot onter the mo	de or dying, suc	m as cardiac or	respiratory sires	interval Between
within 24 ho operation, of cremation, of		iMMEDIATE CAUSE (Final disease or condition resulting in death)	Aging in	Mum	Il lin		Endre	De.	Onset and Death
completely ial, cremati event, t		roading in douting	DUE TO (OR AS A CO	NSEQUENCE OF	" Jen	ency -	green	112	geens
ati pri	NO O	Sequentielly list conditions,	reumorg	plus	prece	induo			3 ments
ertificate be execute ng physician and co giene prior to buria	ERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CO	ASEGUENCE OF	n //				
certificate ding physi tygiene pri	IFI	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CO	NSEQUENCE OF	9:				
F Tag	ERT	resulting in death) LAST							
		PART ii. Other eignificant conditions	contributing to deeth but n	ot resulting i	n the underlying	g ceuee given in	Part i. 24a. W	AS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
that the house of	DICAL						1 □ Y	RFORMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE
requires thaten signed of Health a	ME					4			OF DEATH?
has been be Dept. of In 23 sho	AN:	DID TOBACCO USE CONTR	IBUTE TO CAUSE OF D	EATH YE	S 🗆 NO 🗵	UNCERTAI	N 🗆		
V: The cate ha State D	ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. I HQSPITAL:	PLACE OF DEAT	H (Check only one) OTHER:				
SICIAN: The certificate I h the State d, or Item	PHYSICI	1 TYES 2 NO 27. MANNER OF DEATH	Inpatient 2 ER/Outpatier 28s. DATE OF INJURY		4 - Nursing Hom	e 5 🗆 Residence			
NG PHYS fter this cath with marked		1 Netural 5 Pending	(Month, Day, Year)	28b. TIMI INJ	URY WO	URY AT PRK? YES 2 NO	28d. DESCRIBE I	IOW INJURY OCCUP	1ED
UDING F t: After r death is mar	р ву	2 Accident Investigation 3 Suicide 6 Could not be	26a. PLACE OF INJURY — A	it home, farm, a			281. LOCATION (S	itreet and Number or	Rural Route Number,
THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the THE FUNERAL DIRECTOR: After this certificate has been signed by the filed within 72 hours after death with the State Dept. of Health and M PORTANT: If Item 28 is marked, or Item 23 shows any inje	끧	4 Homicide determined	building, atc. (Specify)				City or Town,	State)	
TAL DR / AL DIRE 72 hours	COMPLE		IAN: To the beat of my knowledge						
HOSPITAL FUNERAL WITHIN 72	00	2 MEDICAL EXAMINER	: On the basis of examination and	f/or investigation	n, in my opinion, d	eath occured at the	time, data and pla	ca, and due to the c	ause(s) and manner as stated.
TO THE HOSPIT TO THE FUNERA De filed within 7	H	296. SIGNATURE AND TITLE OF CERTIFIER	0. () m	\supset		29c. LICENSE NUI	WBER	29d. DATE S	IGNED (Month, Day, Year)
5 5 \$ 3	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	OTEM 27) (5me	Print)	A.00	(dd)	1-7/	6/95

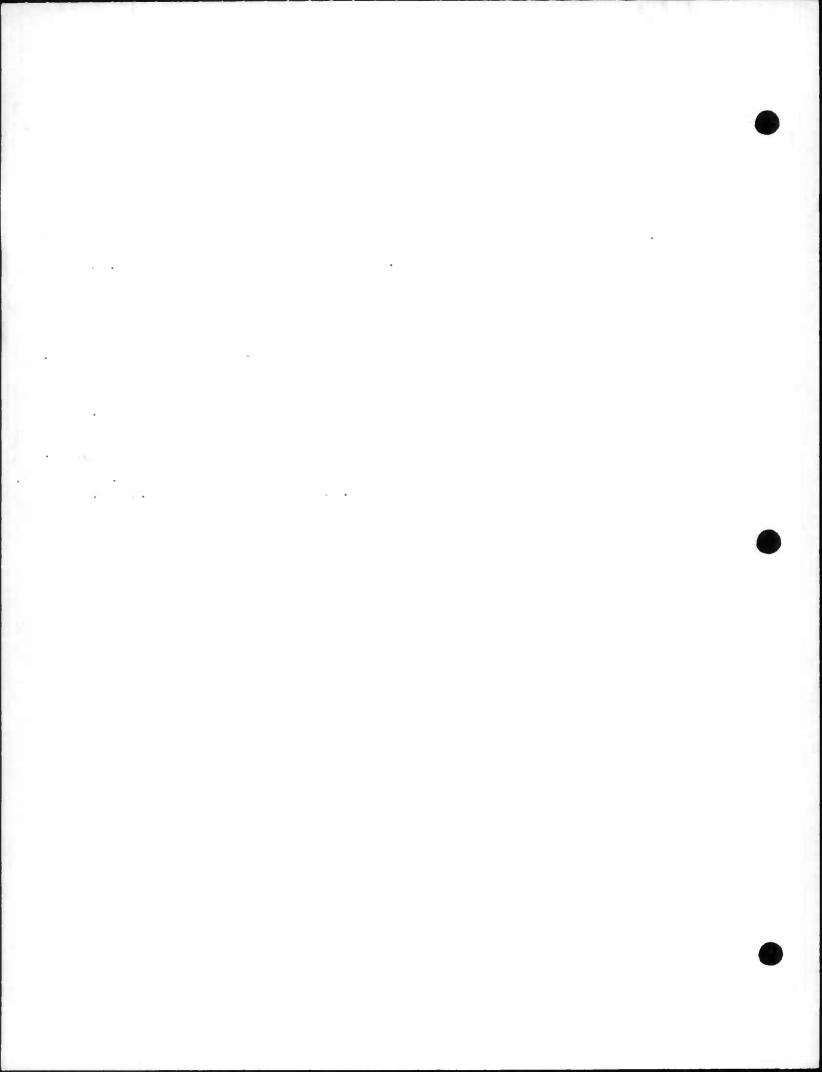
DHMH-18 Rev 1/89



					95 2	0858				
	1 - FOR STATE (F MARYLAND / DEPAI	RTMENT OF HEALTH	AND MENTAL HYGIENE 'H REG. NO.	:					
	1. DECEDENT'S NAME (First, Middle, Last) DELORES MICHELE JONES			2. DATE OF DEATH MONTH DAY JULY 6	7 1995	7:15 p.m.				
	4. SOCIAL SECURITY NUMBER 5. SEX 1 □ M 2 7	6. AGE (In yrs. lest birthday) 54 YRS.	IF UNDER 1 YEAR IF UNDER MONTHS DAYS HOURS		1 BIRTURI	ACE (State or Foreign				
R	9a. FACILITY NAME (If not institution, give street and number Stella Maris	7)	96. CITY, TOWN OR LOCATION Dulaney	ON OF DEATH	9c. COUNTY OF DEAT	TH .				
DIRECTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		ry, town or location	- Table 1		d. INSIDE CITY				
	MD Baltimo	re	Randallsto		10g. CITIZEN OF WHA	LIMITS?				
FUNERAL	3534 Carriage Hill	_	104 211	L33	U.S					
B₹	1 Never Married 2 Married FORCES?	EDENT EVER IN U.S. ARMED 1 YES 2 NO VE WAR OR DATES	13. WAS DECENDENT O	F HISPANIC ORIGIN? (Specify Year n, Mexicen, Puerto Ricen, etc.) Specify:	Black, W	American Indian, Inita, etc. Black				
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4)	(Give kind of life, Do NOT u	S USUAL OCCUPATION work done during most of working se retired.) 1 Strative A	166. KIND OF BUSI		Admin				
BE COM	17. FATHER'S NAME (First, Middle, Last) John Henry Jones	L	16. MOTH	er's NAME (First, Middle, Maiden S						
TO B	19a. INFORMANT'S NAME (Type/Print) Deborah Fields 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 3534 Carriage Hill Circle #104Rand									
	20b. PLACE AND DATE OF DISPOSITION 1									
	23. PART I. Enter the diseases, or complications	CFSP #2	81 E.L.Phil	lips F/H Bal	lto., MD	. 21217				
	ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):									
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING									
ERTIFICATION	CAUSE (Disease or Injury that initiated eventa resulting in death) LAST C. DUE TO (OR AS A CONSEQUENCE OF):									
EDICAL C	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?									
Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
YSICIAN:		26. PLACE OF DEA	OTHER: 4 Nursing Home 5 Res	sidence 6 X Other (Specify)	Hospice					
ву рну	1 Natural 5 Pending (Mor		M 1 YES 2	28d. DESCRIBE HOW INJ	JURY OCCURED					
a	3 Suicide 8 Could not be 4 Homicide datermined	CE OF INJURY — At home, farm, ling, atc. (Specify)	street, factory, office	281. LOCATION (Street end City or Town, State)	d Number or Rural Route	Number,				
COMPLET	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis					d manner as stated.				
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	000000000	29c. LICEI	NSE NUMBER	29d. DATE SIGNED (Md	onth, Day, Year)				

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DR. KENDALL FAULKNER. 2300 DULANEY VALLEY RD., TOWSON, MD



DIVISION OF VITAL RECORDS, P.O. BOX 68760 BA HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death cartificate be ensured within 34 hours after or	~	- 6
DIVISION OF VITAL RECORDS, P.O. BOX 68760 HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours	m	after
DIVISION OF VITAL RECORDS, P.O. BOX 68760 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cardificate be executed within 3 in		OULS
DIVISION OF VITAL RECORDS, P.O. BOX 68760 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within		5
DIVISION OF VITAL RECORDS, P.O. BOX 68760 HOSPTAL DR ATTENDING PHYSICAN: The law requires that the death certificate be executed with		E
DIVISION OF VITAL RECORDS, P.O. BOX 687, HOSPIAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed	9	*
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH JOHN R. JULY YEAR KEIL 5.30 A 1995 09 4. SOCIAL SECURITY NUMBER 5 SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 D F 215-09-2110 84 July4,191 Maryland Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give stre 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF GEATN 2917 Virginia Avenue DIRECTOR Baltimore Highlands Baltimore RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Baltimore Highlands 1 TYES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2917 Virginia Avenue use as the burial-transit 21227 United States retained by the hospital or attending physician, 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried If yes, specify Cuben, Mexican, Puerto Ricen, etc. 1 TYES 2 DE NO BY Specify: 3 Widowed 4 Divorced Specify: white 8 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only H funeral director, page 5 should be detached for College (1-4 or 5+) COMPL 10 engineer electronics 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) 76 Charles F. Keil BE Olympia Keil notified 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21227 19e. INFORMANT'S NAME (Type/Print) 2 Evelyn Keil 2917 Virginia Avenue Baltimore, Maryland eath. Page 6 may be 9 20b. PLACE AND DATE OF DISPOSITION (Name of must b 20c. LOCATION -- City or Town, State OATE cometery, crematory or other place)
Loudon Park Cemetery on Specify) 7/11 Baltimore, Maryland examiner NERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Ambrose Funeral Home, Inc Arbutus 1328 Sulphur Spring Road of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Jagan the 21227 the medical in by t Approximata shock, or heart failure. Elst only one cause on each line. interval Between 6 filled IMMEDIATE CAUSE (Final PULMONARY DISEASE Onset and Death disease or condition cremation. OBSTRUCTIVE HRONIC completely EARS reaulting in death) traumatic event, DUE TO (OR AS A CONSEDUENCE OF) prior to burial, CERTIFICATION and Sequentially list conditions, OUE TO (DR AS A CONSEDUENCE OF): if any, leading to immediate cause. Entar UNDERLYING the attending physician Mental Hygiene prior tr CAUSE (Disease or Injury or other DUE TO (DR AS A CONSEQUENCE OF) that initieted eventa resulting in death) LAST Injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS and t AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? PERFORMED? shows any signed Health a 1 TYES 2 JAM 1 YES 2 NO been 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES YOU UNCERTAIN PHYSICIAN: has b 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate I HOSPITAL OTHER: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 YES 2 -NO 4 Nursing Nome 5 Healdence 6 Other (Specify) 6 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 26d, DESCRIBE HOW INJURY OCCURED marked. this with 1 - Hillurel 5 Pending М 1 YES 2 NO BY After t 2 Accident 26e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 69 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED 6 Could not be DIRECTOR: hours after 4 Homicide 28 29e. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. COMPL (Check only one) TO THE HOSPITAL TO THE FUNERAL (De filed within 72 h 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year, BE 2 140491 July. 10. 1995 2 SU. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

SYED M.A. RIAZ 800 N. HAM MON 800 N. HAMMONDS FERRY RUAD M.A. RIAZ INTHICUM 21090 July 32 Hall Table Kingliff

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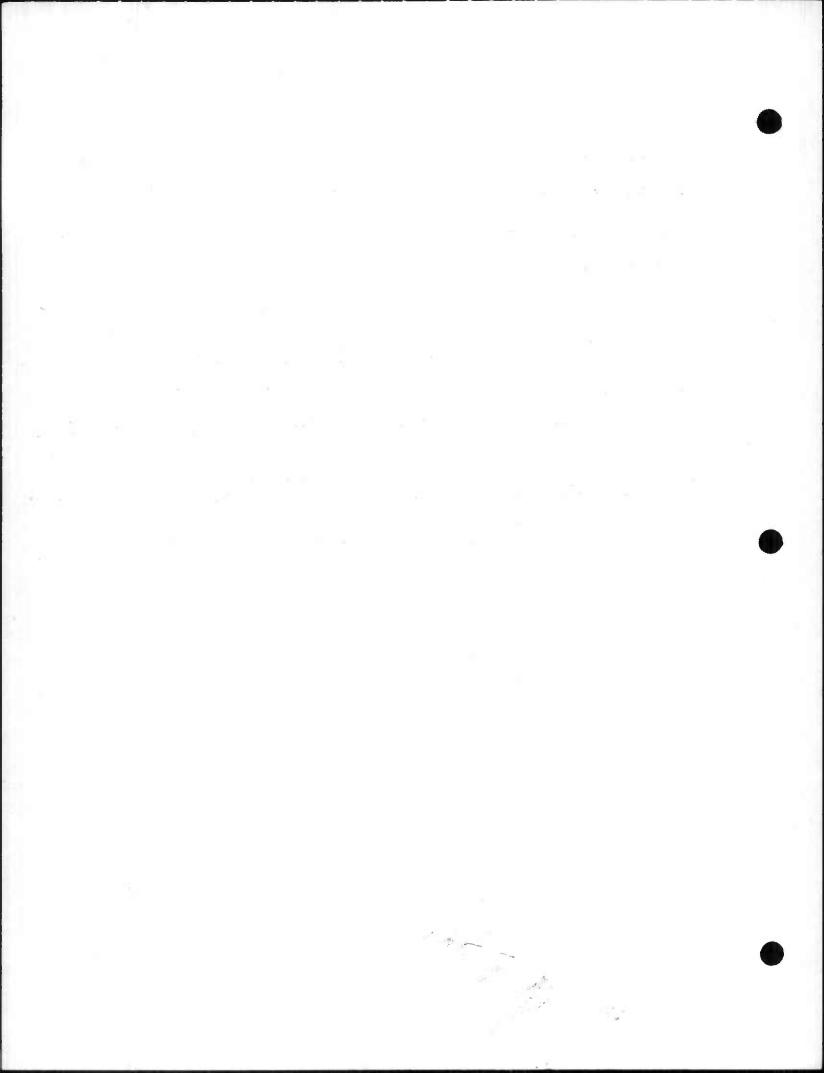
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

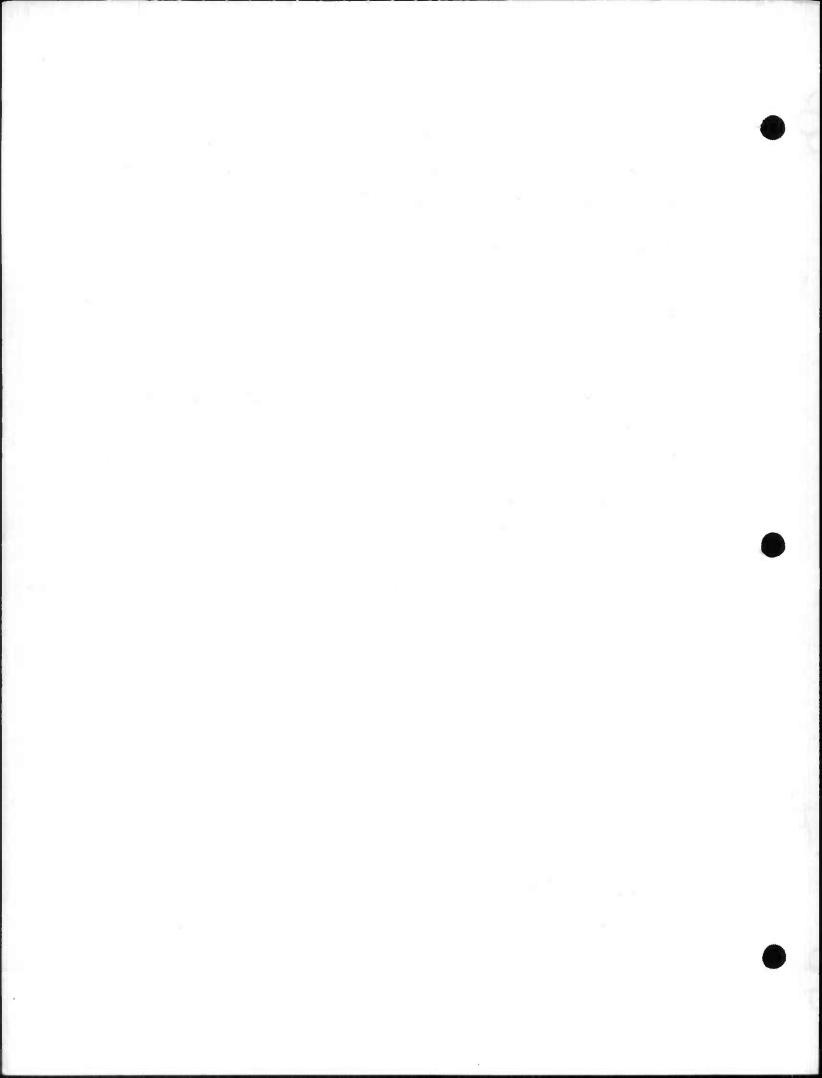
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

R ATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
GISTRAR	CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF M	ARYLAND /	DEPAR	TMENT	OF H	EALTH	AND	MENTAL	HYGIEN REG. NO	E			
	1. OECEDENT'S NAME (First, Middle, Last)									OF DEATH			3. TIME OF DEA	TH
	Sonya	Ε.	Krausi	man					July	9,1		YEAR	5:20	рм
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	st birthday)	IF UNDER	t YEAR	IF UNDER	24 HRS.	7. DATE O	OF BIRTH	773	8. BIRTH	IPLACE (State or F	
	218 01 7749	1 🗆 M 2 🔀 F	77	YRS.	MONTHS	DAYS	HOURS	MIN.		16 1	918	Counti	yland	
	9a. FACILITY NAME (If not institution, give street	et end number)			9b. CITY,	TOWN C	R LOCATI	ON OF O		,.		NTY OF D		
DIRECTOR	214 Long Cove La	ane			Es	sex					Bal	time	ore	
HE	10s. STATE 10b. COUNTY			10c. CIT	Y, TOWN O	R LOCAT	ION						10d. INSIDE CIT	,
L 0	Maryland Baltin	nore			Es	sex	ZIP CODI				1 TYES 2X NO			NO
FUNERAL	214 Long Cove La	ane				101	212					S.Z	VHAT COUNTRY?	
5	11. MARITAL STATUS	2 WAS DECEDENT	EVER IN U.S. AR	RMED	13. 1	MAS DEC	ENDENT O	F HISPAI	NIC ORIGIN	(Specify Yes		14. RACE	- American Indi	in.
	1 Never Merried 2 Married	FORCES? 1	YES 2	NO			city Cuba 2 XNO		in, Puerto R	ican, atc.)		Speci	c, White, atc.	,
BY	3 Widowed 4 Divorced						-X					Орос	White	
COMPLETED	15. DECEDENT'S EDUCA' (Specify only highest grade co	TION impleted)	(G	CEDENT'S	work done o	CUPATIO	N st of workin	g	16b.	KIND OF BUS	SINESS/IND	USTRY		
PLE		College (1-4 or 5+)		. Do NOT us										
MC	10 17. FATHER'S NAME (First, Middle, Last)		Adı	nini	stra	tiv	e A	sst	<u> </u>	artir	Co	npar	ıv	
	Frank Mellon													
) BE	19e. INFORMANT'S NAME (Type/Print)		191	b. MAILING	ADDRESS	(Street a	nd Number	or Rural	A B Route Numb	ertra	n, State. Zio	Code)		
٥	David Krausman		1										21087	
	20e. METHOD OF DISPOSITION 1 1 Buriel 2 Cremation 3 Remove	ni trom State	20b. PLACE	AND DATE (OF DISPOSI	TION (Na	me of		OATE		CATION —			
	4 Donetion 5 Other (Specify)		Most	Holy	Rede	eme	2	7/	12/95	Bal	timor	e, I	Maryland	1
	21. SIGNALURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Bruzdzinski Funeral Home P.A.													
	1407 Eastern Ave Baltimore, Maryland 21221													
	23. PART Enter the diseases, or cor	mp cations that	caused the de	eth. Do n	ot enter	the mo	de of dyl	ng, suc	h as cardi	ec or respi	ratory en	eat,	Approxim	
	Interval Between IMMEDIATE CAUSE (Final													
	disease or condition resulting in death)	CHRON	NIC OBS	STRU	CTIV	E F	ULM	ONA	RY D	ISEAS	βE.		YEAF	S
		DUE TO (OR AS A CONSEC	DUENCE OF	F):									
ON	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):													
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OH AS A CONSEC	DUENCE OF	·):									
음	CAUSE (Disease or Injury 6.													
E	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST													
													-	
A	N20	PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PRIOR TO AMAILABLE PRIOR TO												
73	UIABETES MELLITUS CO										COMPLETION OF	AUSE		
DIC	DIABETES MELL								_		NO		OF DEATH?	
MEDIC/		ITUS							_		NO		OF DEATH?	10
AN: MEDICA	DID TOBACCO USE CONTRIB	ITUS	JSE OF DEA			_	UNC	ERTAIN	_		NO			10
ICIAN: MEDICA	DID TOBACCO USE CONTRIB	TTUS BUTE TO CAL	JSE OF DEA 26. PLAC	E OF DEAT	H (Check o	nly one)	_	ERTAIN	V D	1 TYES 2	NO			10
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BY PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2	BUTE TO CAL OSPITAL: One of income to the control of the control	JSE OF DEA 26. PLAC ER/Outpatient 3	DOA 28b. TIMI	OTHER 4 Nurs E OF URY	ing Home 28c. INJU WOF	S PE	ERTAIN Mederice	6 Other 28d. DESC	1 ☐ YES 2	JURY OCC		1 YES 2 1	10
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BY PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIE 25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1	BUTE TO CAL OSPITAL: Inpetient 2 26a. OATE OF I (Month, Da) 28c. PLACE OF building, a	JSE OF DEA 26. PLAC ER/Outpatient 3 NJURY · Year) INJURY — Al hor ic. (Specify)	DOA 28b. TIMI	OTHER 4 Nurs E OF URY M street, factor	ing Home 28c. INJL WOF 1 Yery, office	FS 2 Interest of the second place,	ERTAIN Midence NO end due	6 Other 28d. DESC 28t. LOCA City of	1 YES 2 (Specify) CRIBE HOW IN TION (Street e Town, State)	nd Number	or Rural A	1 YES 2 U	
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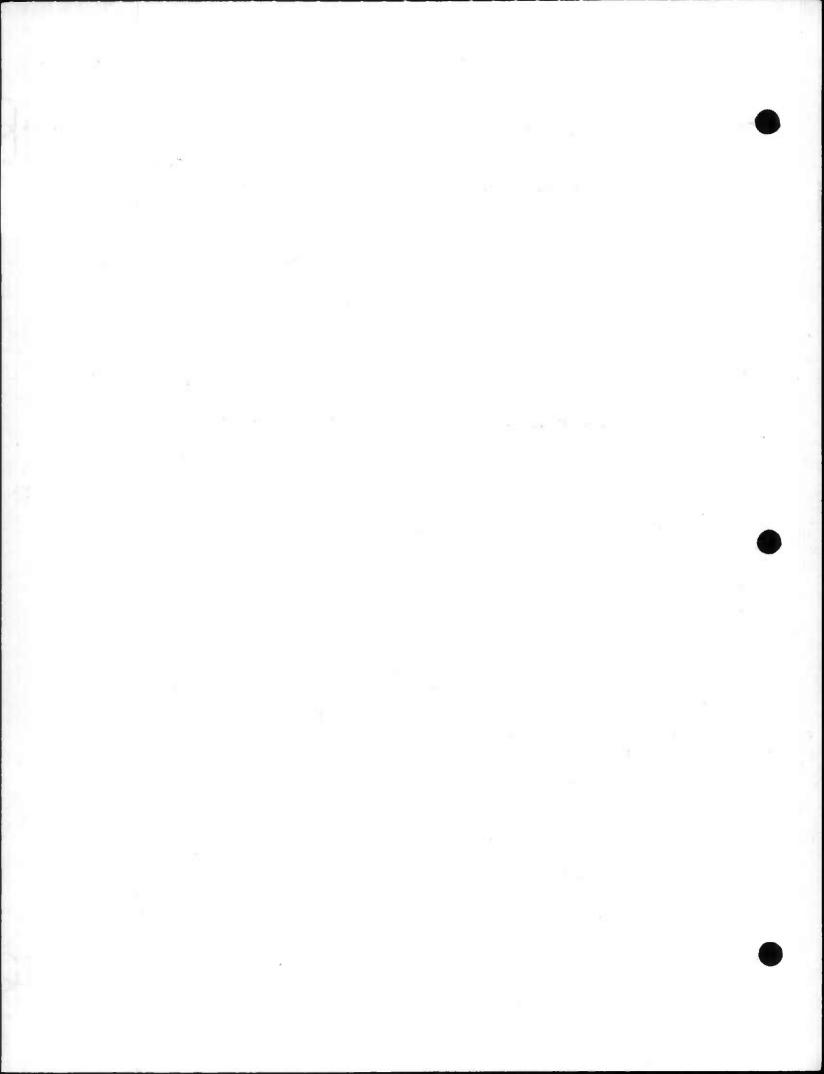
		FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTI			MENTAL HYGIEI	_				
		1. DECEDENT'S NAME (First, Middle, Last) ANNA BARE	BARA KI	VAUFF				0,1995	3. TIME OF DEATH			
2		4. SOCIAL SECURITY NUMBER 214-24-5783	5. SEX 6. AGE (In	yrs. last birthday)	F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) FEB 25,	8. 8	MRTHPLACE (State or Foreign Country) MARYLAND			
, 2, 3 should	CTOR	99. FACILITY NAME (If not institution, give str GOOD SAMARITA RESIDENCE OF DECEDENT				OR LOCATION OF DE		9c. COUNTY				
it. Pages 1,	DIREC	10a. STATE 10b. COUNTY	ultimore		TOWN OR LOCAT	TION			10d. INSIDE CITY LIMITS? 1 YES 2 NO			
an. ransit permit.	FUNERAL	1509 Cleary	sood Rd.			2123	4		OF WHAT COUNTRY?			
215-0020 attending physician. se as the burial-transit	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN I FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 NO		IC ORIGIN? (Specify Yen, Puerto Rican, atc.)		RACE — American Indian, Black, White, atc. Specify: WHITE				
21. g g g	ETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	UAL OCCUPATION done during mostired.)	ON sst of working	166, KIND OF BU	JSINESS/INDUST	The second secon				
MARYLAND 2 retained by the hospital 5 should be detached to netified at once.	COMPL	17. FATNER'S NAME (First, Middle, Last)	NA Clarry	House	WIFE		ME (First, Middle, Maide	n Surname)				
retained by 5 should be notified at	TO BE	190. INFORMANT'S NAME (Type/Print) JEAN OLSE!		196. MAILING AD			loute Number, City or To		(o)			
ay be		20a. METHOD OF DISPOSITION 1	20b. P	PLACE AND DATE OF I	DISPOSITION (No.	ON Ave	DATE 20c. L	OCATION - City	or Town, State			
ALTIN death. Pag funeral dii		21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE	<u>putimore</u>	22. NAME AN	ID ADDRESS OF FAC	YTLIK	eltimore Emorie	5, Md.			
hin 24 hours aft lefy filled in by mation, or remo t, the medica		23. PART I. Enter the diseasea, or company and the second	List only one ceuse on eed	ch line.	enter the mo	de of dying, auch	aa cardlac or resp	olretory arrest,	Approximate Interval Between Onset end Death (48 Int)			
P.O. BOX 68 th certificate be executed by the physician and in Hygiene prior to bur or other traumatic	CERTIFICATION	disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
RECOR requires that en signed by of Health and shows any	MEDICAL	PART II. Other algnificant conditions	contributing to death but	it not resulting in t	the underlying	g cause given in I		RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
VITAL F N: The law licate has be State Dept.	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpat	elege 2 DOA	THER:	ACE OF DEATH (Che						
NOF VIT, NG PHYSICIAN: Th frer this certificate eath with the State marked, or Iten		27. MANNER OF DEATN 1 Natural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME O	26c. INJI	URY AT RK?	8 Other (Specify) 26d. DESCRIBE HOW	INJURY OCCURE	.0			
DIVISION OF VI- OR ATTENDING PHYSICIAN: DIRECTOR: After this certifica hours after death with the Siz Item 28 Is marked, or It	ETED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Nomicide determined	28s. PLACE OF INJURY - building, stc. (Specify	— At home, farm, stree			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
7 40 0	COMPLE		CIAN: To the best of my knowled B: On the basis of examination a						use(a) and manner as stated.			
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5		DR. Charles Ho	esch 9712	2 Bel. Air	-	Balto	Md 21:	236				
		31. DATE FILED MOTTO 1995	A PEGITIPAR SIGNA	THE STATE OF THE S								



BALLIMORE, MARILAND 21213-0020	ted within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit narmit Panes 1.2 sehauld	ial, cremation, or removal.	d, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
CONTRACTOR OF THE CORDS, F.C. BOX 607 00	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: it liem 28 is marked, or item 23 shows any injury, or other traumatic	

Item7_Film725,7/11/95
1-STATE
REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

	1. DECEDENT'S NAME (First										2. DATE OF DEATH			3. TIME OF DEATH
	KLE	ΩE_{1}	MARY	L							MONTH 07	DAY	1995	6.51 PM M
	4. SOCIAL SECURITY NUME	BER	5. SEX	8. AGE	(In yrs. lesi	t birthday)	IF UNDE		IF UNDE		7. DATE OF BIRTH (Month, Day, Year) 1936 8. BIRTHPL/ Country)			PLACE (State or Foreign
	217-32-96		1 M 2 F	5	9	YRS.	MONTHS	DAYB	HOURS	MIN.	June 18	1930		yland
	9e. FACILITY NAME (If not in				9b. CITY	, TOWN	OR LOCAT	ON OF DE		-	UNTY OF D			
6	Harbor Ho		1 Cente	er			Ва	lto	.Ci	ty, N	ſd.		no	ne
	RESIDENCE OF DEC	10b. COUNTY				100 CIT	Y, TOWN	001004	FION					
DIRECTOR	Maryland		.A.Co.			100. 011								10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	A	. H. CO.				Br		lyn		1 ☐ YES XX NO			
1 2	3	912 Ti	nner Ci	rcl	٩			"		1225				States
FUNERAL	11. MARITAL STATUS	712 1	12 WAS DECEDED	IT EVED II	NIIC ADI	MED	13.	WAS DEC				_	_	- American Indian.
	1 Never Merried 2 Merried FORCES? 1 YES 2 NO If yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, V									, White, etc.				
BY	Specify: Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 22 NO Specify: W										White			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working													
in in	(Specify only highest grade completed) [Give kind of work done during most of working life. Do NOT use retired.) [Give kind of working life. Do NOT use retired.)													
N N	12th.Grad		none		H	omen	nake	r	,			n Ho		
	17. FATHER'S NAME (First, M	1000									ME (First, Middle, Maid			
BE	19a. INFORMANT'S NAME (7	Will:	iam			aver					aret R			
2						912					Noute Number, City or T			
	Mr. Willia		lehe			_				сте	Brookly			
	TV Burlel 2 Cremation 4 Donation 5 Other	n 3 🗆 Remo	vel from State	cen	PLACE A	natory or o	ther place)	G	ime of	_	DATE 95 A	OCATION -	- City or To	wn, State
	21. SIGNATURE OF FUNERA			- 10	eaa.	C HI	22.	NAME AL	O ADDRE	SS OF FA	/ II / A			
	> HE	Perter	ul La	, Un										.Md.21230 E.Fort Ab
	23. PART I. Enter the di	seeses, or co	omplications the	t ceused	the dea	nth. Do r								Approximate
	ahock, or he IMMEDIATE CAUSE (Fin	pert fallure. L	list only one ceu	ise on e	ech iine.			1000				p		Interval Between
	disease or condition	ial .	Hyn	4 V /C	0.	C . A	1.01	1	11.					Onset and Death
	resulting in death)		Ay DO	(OR AS A	CONSEO	UENCE OF	7:	CDA	7					
z								/	V					
CERTIFICATION	Sequentially list conditi if any, leading to immed	diate	DUE TO	(OR AS A	CONSEO	UENCE OF	·):							
S	cause. Enter UNDERLYI CAUSE (Disease or Inju													
빌	that initiated events resulting in death) LAS		DUE TO	(OR AS A	CONSEO	UENCE OF	7:							
胃		d												
	PART II. Other algnifice	nt conditions	contributing to	deeth b	ut not re	euiting i	n the un	derlying	ceuse (lven in		N AUTOPSY	24b.	WERE AUTOPSY FINDINGS
MEDICAL											PERF	DRMED?		AVAILABLE PRIOR TO COMPLETION DF CAUSE
빌											1 10 123	Z V NO		OF DEATH? 1 YES 2 NO
	DID TOBACCO U	SE CONTR	IBUTE TO CA	USE O	F DEAT	H YE	S 🔲 I	NO [UNC	ERTAIN				
₹	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL			28. PLACE									
Sic	1 YES 2 NO		HOSPITAL:	ER/Outp	atlent 3	□ DOA	OTHER 4 - Nun		• 5 🗆 Re	sidence	6 Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	Pending	28e. DATE OF (Month, D			28b. TIMI	E OF URY		RK?		28d. DESCRIBE HOW	INJURY O	CURED	
BY	A COMMIN	nvestigation	290 PLACE O	E IN ILIDY	44.5		M		/ES 2 [NO				
ETED		Could not be determined	28e. PLACE O building,	etc. (Spec	- At non	ne, rerm, s	treet, fact	ory, office			261. LOCATION (Stree City or Town, Stat	t and Numbe e)	er or Rumal Au	oute Number,
1	29a. CERTIFIER (Check only	IFYING PHYSIC	IAN: To the best of	my knowl	ledge, dea	th occum	d at the t	lme, date	end place	end due	to the cause(e) end m	anner en et	het	
COMPL														and manner ea stated.
	29b. SIGNATURE AND TITLE									NSE NUM				(Month, Day, Year)
BE	_	MAN _	- M	D							614-12			
2	30. NAME AND ADDRESS OF	PERSON WHO												
	TARIAMIR >	A - 71	15# D, K	OLL	NGB	END	RD	, RI	ALTI	M GA	RE, MD	212	44	
	31. DATE FILED (Month, Day,	1995	32. REGISTRA	R'S SIGN	ATURE		4		, , ,		RE, MA	- 1 -	,	
		- 1333	1	Sixtled	u-Ran	dail.								



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

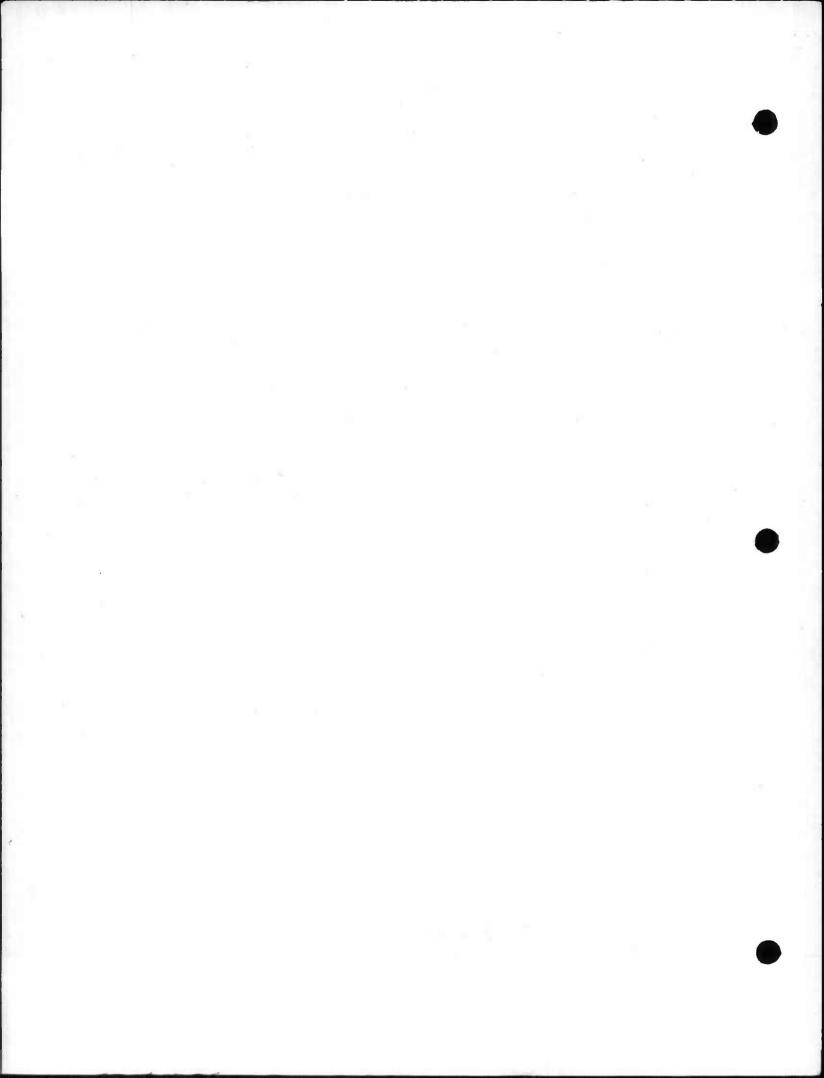
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last DWARD FRANCIS IS KAMM, 2. DATE OF DEATH 3. TIME OF DEATH EDWARD TULY 1995 3:45PM 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Morith, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (Stets or Foreign Pennsylvania 220-01-2758 1/X M 2 - F 28. Nov. 1915 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Church Hospital ious after death. Page 6 may be retained by the hospital or attending physician.

I in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 so removal. DIRECTOR Baltimore RESIDENCE OF DECEDENT 100. STATE Mary land 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore 1 YES 2 | NO 100. STREET AND NUMBER 3971 Brooklyn Avenue FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21225 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yea, specify Cuben, Mexicen, Puerto Rican, atc.)

1 YES 2 NO Specify: 14. RACE — American Ind Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Merried
3 Widowed 4 Divorced FORCES? VI TEO IF YES, GIVE WAR OR DATES WW II ΒY specify: White COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Tank Fitter Bethlehem Steel 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Dominic Kaminski Anna Savage 76 190. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Terri Lynn Gold 3971 Brooklyn Avenue Baltimore, MD. 9 20a, METHOD OF DISPOSITION

1 A Burlel 2 Cremation 3 4 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Verification Action - City or Town, State Verification - City or Town, State examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY
MC Cully Funeral Home of Brooklyn Valerie S. Polyniak 237 East Patapsco Avenue Baltimore, MD. 21225 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or treat feiture. List only one cause on each line. filled in by t Approximate IMMEDIATE CAUSE (Final Onset and Death attending physician and completely fille mal Hygiene prior to burial, cremation, the disease or condition DUE TO (OR AS A CONSCOUENCE PULMONARY LUNG DISEAS resulting in death) event, executed with traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 6 has been signed by the atter Dept. of Health and Mental any injury, PART II. Other eignificant conditions contributing to deeth but not reculting in the underlying ceuse given in Part i. requires that the 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL CANCER 1 YES 2 NO OF DEATHS Shows 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH? YES NO PHYSICIAN: HOSPITAL OR ATTENDING PHYSICIAN: The law I FUNERAL DIRECTOR: After this certificate has be within 72 hours after death with the State Dept. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one Item HOSPITAL:
1 Kinpetient 2 ER/Outpetient 3 DOA OTHER: 1 - YES 2 NO ng Home 5 - Residence 8 - Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED marked, 1 M Natural 5 Pending ВУ 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, tectory, office building, stc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER (Chack ank) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner as stated. = 2 MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the ceuse(e) end menner ea stated. TO THE HOSPITA
TO THE FUNERA
DE FIED WITHIN 72
IMPORTANT: 1 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Yazemi no. 2 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ZEMI, M.O. CHUNCH HOSPETAL

July 30 150 TAP SOUTH



DIVISION OF VITAL RECORDS, P.O. BOX 68760

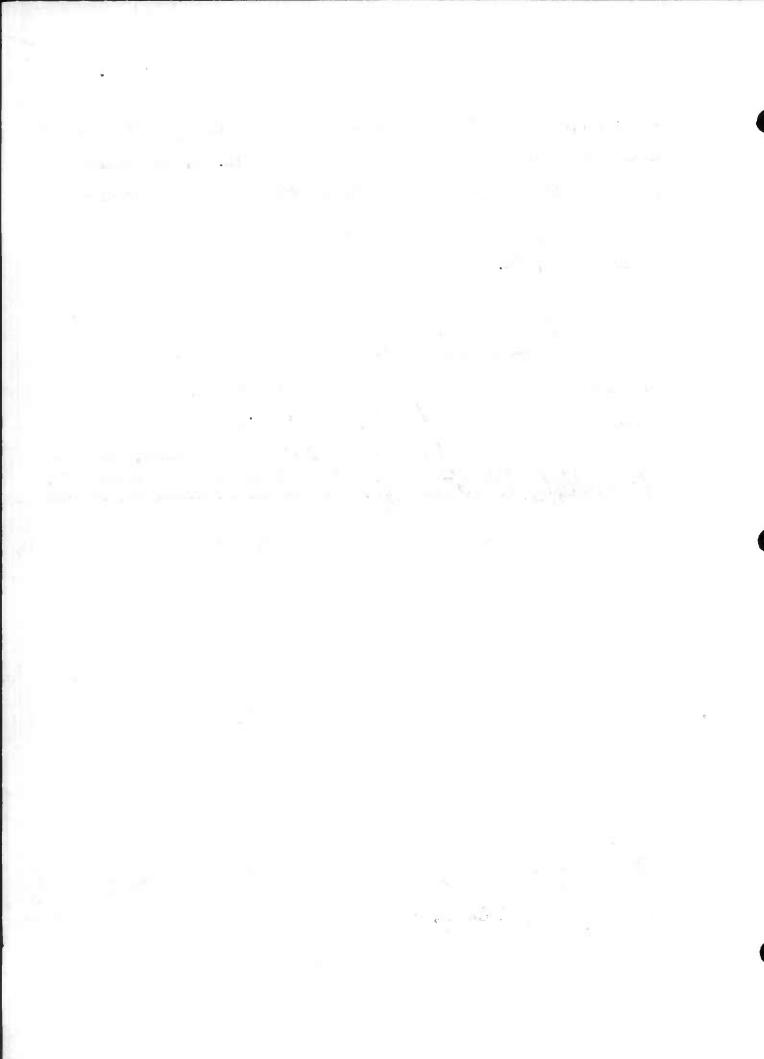
TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 55 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

	1 - STATE REGISTRAR	STATE OF MARY		MENT OF I			YGIENE EG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)				- Little	2. DATE OF C			3. TIME OF DEATH
	Potrm	KL	eymo	a_N		МОНТН	DAY	YEAR	6117 A H
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	E (In yrs. last birthday)	IF UNDER 1 YEAR	F UNDER 24 HRS.	7. DATE OF B	IREL		PLACE (State or Foreign
	213-37-8790	% M 2 □ F	59 YRS.	MONTHS DAYS	HOURS MIN.	Jan .		36 Rus	
	9a. FACILITY NAME (If not institution, give			9b. CITY, TOWN	OR LOCATION OF E			COUNTY OF D	
٣ ا	Holy Cross Hospit	ral		Silver	Spring			Mont	gomery
ל l	RESIDENCE OF DECEDENT			DILVEI	opring			HOHE	gomery
DIRECTOR	10a. STATE 10b. COUNT	ay .	22.00	TOWN OR LOCA	TION				10d. INSIDE CITY LIMITS?
_	New York		B ₁	rooklyn					1XXYES 2 □ NO
≱	10a. STREET AND NUMBER			10	. ZIP CODE		10g	. CITIZEN OF V	VHAT COUNTRY?
FUNERAL	1866 Ocean Avenue				11230			Russia	
2	11. MARITAL STATUS 1 Never Married 2 X Married	12. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. ARMED	13. WAS DEC	ENDENT OF HISPA ecify Cuban, Mexic	ANIC ORIGIN? (Sp	ecify Yea or No	0- 14. RACE	- American Indian,
β	3 Widowed 4 Divorced	IF YES, GIVE WAR OR			2 NO Spec		, 410.7	Speci	
ED	15. DECEDENT'S EDI	UCATION	18e. DECEDENT'S U	ISUAL OCCUPATION				1	White
	(Specify only highest grad Elementary/Secondary (0-12)	le completed)		ork done during mo		16b. KINI	OF BUSINES	S/INDUSTRY	
2		College (1-4 or 5+) 4 Yrs College				C	onstru	ction	
COMPLET	17. FATHER'S NAME (First, Middle, Last)	. III OULLOS	q nanage.		18. MOTHER'S N	AME (First, Middle			
_	Shimon Kleyman								
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING /	ADDRESS (Street a	and Number or Burel	Feyga K			
2	Riva Kleyman		1866 0	cean Ave	enue, Ap	t. 4C	y or rown, oran	14 240 0000)	
	20a. METHOD OF DISPOSITION	20	b. PLACE AND DATE OF	DISPOSITION (Ne			20c. LOCATIO	N — City or To	wn State
	120 Buriel 2 Cremation 3 Ren 4 Donation 5 Other (Specify)	noval from State C6	ount Lebar	er place)	7/03/1	995			aryland
	21. SIGNATURE OF FUNERAL SERVICE LI		• •	22. NAME AL	D ADDRESS OF F	ACILITY			
	1 - 10	1 NT H	M	STEIN	HEBREW	MEMORIA	L FUNE	RAL HO	ME, INC.
-	22 PART I FAME TO A	~./J/M	Demy	1232 CA	ARROLL S	T, NW,	WASHIN	GTON,	DC 20012
	23. PART i. Enter the diseeses, or shock, or heart fellure.	List only one ceuse on	eech line.	ot enter the mo	de of dying, su	ch es cerdiec	or respiretor	y srrest,	Approximate Interval Between
ı	IMMEDIATE CAUSE (Final disesse or condition	. 4	9000			. 4			Onset and Death
	resulting in death)	e. au	erio sc	1 endt	ic t	tearl	Di	Sours	2 manly
		DUE TO (OR AS	A CONSEQUENCE OF)	*					
5	Sequentially list conditions,	b	A CONSEQUENCE OF						
4	if any, leading to immediate cause. Enter UNDERLYING	OUE TO (OTT NO	A CONSCOURNCE OF	•					
HIFICALION	CAUSE (Disease or injury that initiated events	C. DUE TO (OR AS	A CONSEQUENCE OF)	:					
	resulting in death) LAST	3							
3		0,							
¥	PART ii. Other significent condition	ne contributing to deeth	but not resulting in	the underlying	g ceuse given in	Part J. 24s.	WAS AN AUTO		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDIC						1	YES 2 N		COMPLETION OF CAUSE OF DEATH?
Σ						4	, ,		1 _ YES 2 _ NO
2	DID TOBACCO USE CONT	RIBUTE TO CAUSE (OF DEATH YES	□ NO □	UNCERTA	IN Z			
HISICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH						
2	1 YES 2 NO	1 Inpetient 2 ER/Out		OTHER: Nursing Hom	e 5 🗆 Residenca	6 Other (Spe	cify)		
5	27. MANNER OF DEATH	26e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU		URY AT	28d. DEŞCRIB	E HOW INJURY	OCCURED	
	1 Netural 5 Pending 2 Accident Investigation				ES 2 NO				
3	3 Suicide 6 Could not be	28e. PLACE OF INJUR building, etc. (Spe	IY — Al home, farm, str	reet, factory, offic		26f. LOCATION C/ty or Tox		mber or Rural R	oute Number,
	4 Homicide determined					0, 0	ii, dialoy		
MPLE	29a. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the beat of my know	wledge, death occurred	at the time, data	and place, and du	a to the cause(a)	and menner as	s steted.	
5		ER: On the basis of exemination							and manner as stated.
2	29b. SIGNATURE AND TITLE OF CERTIFIE	R			29c. LICENSE NU	MBER	294	DATE SIGNED	(Month, Day, Year)
0	286	En melens	>		200	741	•	7. 1-	2 2 5 5
2	30. NAME AND ADDRESS OF PERSON W	10 COMPLETED CAUSE OF D	EATH (ITEM 27) (Type, F	Print)	4700	2		Jul	0 2 0
	Dohn	Tumber			Scan	C	Ave	7	and ma
		A TENETRAL PO	unture.	_ ~		31.0		- 10	c. with
(JUL 11 1995 A	my marger No	A173						
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ITEM: 4. PER F.H. FILM G-725 7/11/95 t.t

FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH 3. TIME OF DEATH 6894 IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS 8 BIRTHPI ACE (State of 86 June 25 YRS. funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF PEATH Dinail DIRECTOR pita RESIDENCE OF DECEDENT toe. STATE 10b. COUNTY 10c. CITY, TOWN R LOCATION)a XYES 2 NO FUNERAL 3224 STREET AND NUMBER 101. ZIP COOE WHAT COUNTRY? S TWUNNS ours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS

Never Married 2 Merried 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, Whitenets: BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 No Specify: ВУ lack Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION ecify only highest grade comple 18e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY HOT use retired.) e (1-4 or 5+) echnicia 17. FATHER'S NAME (First, Middle, Last) NAME (First, Middle, Maiden Su num notified at ae BE 2 5 pe METHOD OF DISPOSITION 20c. LOCATION -PLACE AND WATE OF DISPOSITION (N) Top mo must tho bat tawn Pm mo 5 COther (St 22, NAME AND ADDRESS OF FACILITY examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 4300 Ave filled in by the fi bas wa medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximats shock, or heart fellure. List only one cause on each line Interval Between Onset and Deeth IMMEDIATE CAUSE (Final n and completely fille to burial, cremation, the diseese or condition completely (resulting in death) event. DIVISION OF VITAL RECORDS, P.O. BOX 68760, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed wit traumatic CERTIFICATION Sequentially list conditions, (OR AS A CONSEQUENCE OF) If any, leading to immediate attending physician mal Hygiene prior to cause. Enter UNDERLYING CAUSE (Diseese or Injury other 1 QUE TO (OR AS A CONSEQUENCE OF) that initiated evente resulting in death) LAST 0 been signed by the attent. of Health and Mental injury, PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse PHYSICIAN: MEDICAL AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 - YES 2 NO OF DEATH? 1 YES 2 NO this certificate has by with the State Dept. Item 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? OTHER npetient 2 ER/Outpetient 3 DOA ng Home 5 🗆 Reeldence 6 🗆 Other (Specify) 0 27. MANNER OF DEATH 28e, DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 5 Pending 1 YES 2 NO BY After 1 death Accident Investigation 3 Sulcide 28e. PLACE OF INJURY — At home, ferm, streat, factory, office building, stc. (Specify) 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) 49 ED 8 Could not be FUNERAL DIRECTOR: within 72 hours after 4 Homicide 28 determined COMPLET item ; 29e. CERTIFIER To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) and manner se stated. TO THE HOSPITAL
TO THE FUNERAL
Be filed within 72 P
IMPORTANT: If I HOSPITAL examination and/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(a) end manner ee stated. 29d. DATE SIGNED (Month, Day, Year) BE 2 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1995 32. REGISTRAR'S SIGNATURE

Devoler Karlell

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

DHMH-18 Ray 1/89

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JUNE 12/4/5 6-15 P

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		REGISTRAR	OF MARYLAND	/ DEPART	TMENT OF H	EALTH AND	MENTAL HYGIEN					
		1. DECEDENT'S NAME (First, Middle, Last) BERTH		RSEN			2. DATE OF OEATH	8 199	S 4.22 PM			
9		4. SOCIAL SECURITY NUMBER 5. SEX 214-20-6595 1 D M 2	6. AGE (In yrs. 95		F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Yber) June 28,	1900 M	BIRTHPLACE (State or Foreign Country) [aryland			
3 should	E E	98. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH										
s 1, 2,	DIRECTOR	Forest Haven 315 Ingleside ave Catonsville Baltimore RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY										
permit. Pages	DIRI	Maryland N/A			ltimor				10d. INSIDE CITY LIMITS? XXYES 2 NO			
	ERAL	100. STREET AND NUMBER 820 S. Caton Avenu	0		101	21229	2		OF WHAT COUNTRY?			
020 physician. burial-transit	FUNE	11. MARITAL STATUS 12. WAS DE	ECEDENT EVER IN U.S.	ARMED		ENDENT OF HISPAI	IIC ORIGIN? (Specify Ye		RACE - American Indian,			
21215-0020 al or attending physician. for use as the burial-tran	B		S? 1 YES 2 GIVE WAR OR DATES	Mio		ecify Cuben, Mexica 2 XNO Specif	n, Puerto Rican, etc.)		Black, White, atc. Specify: White			
2121	LETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)		DECEDENT'S L (Give kind of willing) Do NOT use	JSUAL OCCUPATION done during mo	ON est of working	16b. KIND OF BU	SINESS/INDUST				
od for	MPLE	Elementary/Secondary (0-12) College (1	-4 or 5 +)		stress		self.	-emplo	ved			
/LAP	COMP	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maider					
	8 8	James Holden 194. INFORMANT'S NAME (Type/Print)		19b. MAILINO	ADDRESS (Street a		nia N/A Poute Number, City or Tox	vn. Statu. Zip Coo	de)			
2 8	2	H. Stephen Roberts					#302 Tin					
E E	Tana I	20e. METHOD OR DISPOSITION 1 Device 2 Commention 3 Demonstrum St 4 Demonstrum FN Other (Specify)	cemetery, c	cremetory or oth	F DISPOSITION (No			CATION — City				
ALTIN death. Pag funeral dir	examilia	21. SINGUITHE OF PRIMERAL BERVICE LICENSEE	Mec	10 01	Ambr	OSE Fur	neral Hon	ne, In				
after Day the thought		23. PART I. Enter the diseases, or complication	ns that coused the	death. Do no			r Spring					
y filled in	event, the me	shock, or heart failure. List only of IMMEDIATE CAUSE (Final disease or condition resulting in death)	Shage DUE TO (OR AS A JONS		onic o	Betruct	ive lunc	y dise	Interval Batween Onset and Death			
		Sequentially list conditions,	DOE TO (OH AS AVGONS	EQUENCE OF)	i.			U				
ior be	ATION	If any, leading to immediate cause. Enter UNDERLYING										
S, P.O. Bodeath certificate attending physiental Hygiene pr	CERTIFICATION	CAUSE (Disease or Injury that Initiated events resulting in death) LAST	DUE TO (OR AS A CONS									
		PART II. Other significant conditions contribut	ing to death but not	resulting in	the underlying	ceuse given in	Part I. 24s. WAS AN	AllTOPSV	24b. WERE AUTOPSY FINDINGS			
uires that	MEDICAL	large trovacic and	abdoni	rali	aortic	aneur	PERFO	RMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
AL KI		DID TOBACCO USE CONTRIBUTE TO				UNCERTAIN	V 🗆					
SICIAN: The certificate h	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpute			OTHER:	e 5 🗆 Rasidenca	A (0) - (0 - 11)					
HYSICIA nis certif	PHY:	27. MANNER OF DEATH 28s. D	ATE OF INJURY fonth, Day, Year)	28b. TIME	OF 28c. INJ		28d. DESCRIBE HOW	NJURY OCCURE	ED			
DING PI After th	BY PH	2 Accident Investigation	LACE OF INJURY — At I	home form et	M 1 🗆 1	rES 2 NO	201 0.0471011 (0					
DR ATTENE DIRECTOR: hours after	ETED	4 Homicide detarmined	uliding, atc. (Specify)	Tome, lettil, at	- Control of the cont		28t. LOCATION (Street City or Town, State)	and Number or H	urai Houte Number,			
Z ZZ	COMPLET	29e, CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the bar							use(s) and manner as stated.			
TO THE HOSPITAL TO THE FUNERAL De filed within 72 I	BE	296. SIGNATURE AND TITLE OF CERTIFIER OUD PORT	2120			29c. LICENSE NUN D1836	IBER	29d. DATE SIG	GNED (Month, Day, Year)			
10	2	30. NAME AND ADDRESS OF PERSON WHO COMPLETE					0-4-	10/-0				
10		31. DATE FILED (Month, Day, Year)	3455	, Will	Kens	Hve,	Ballo.,	INCO!	21229			
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2	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely ment in your mentured page 5 should be detached for use	be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or memoral.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing finance and the may be retained by the hospital or art			

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTI	FICATE (F DEATH	REG. NO).				
	1. DECEDENT'S NAME (First, Middle, Last	,				2. DATE OF DEATH MONTH D	MY	YEAR	3. TIME OF D		
	ED		LUST	THE COLUMN			1995	TEAN	8	A	M
	4. SOCIAL SECURITY NUMBER		NGE (In yrs. last birthda	MONTHS DA		7. DATE OF BIRTN (Month, Day, Year)	1	8. BIRTHP Country)	PLACE (State o	or Foreign	,
	216-10-4424	1 D M 2 D F	92 YRS	- Inomina DA	NOUNS MIN.	JAN. 8,1	903		USSIA		
_	9e. FACILITY NAME (If not institution, give			96. CITY, TO	N OR LOCATION OF DE	EATN	9c. COUNT				
6	NORTHWEST HOSPIT	AL CENTER			RANDA	ALLSTOWN	BA	ALTIN	MORE		
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUN	TV	1 40.	ATY, TOWN OR LE							
E	100.000	BALTIMORE	100.		TIMORE			- 1	10d. INSIDE (3.7	
	10e. STREET AND NUMBER	DANITION		DAL					1 YES 2		
RA	6945 BROOKMILL R	OND			101. ZIP CODE 21215	5	USA	EN OF W	HAT COUNTR	177	
FUNERAL	11. MARITAL STATUS										
	1 Never Married 2 Married	12. WAS DECEDENT EV FORCES? 1 1	YES 2 NO		DECENDENT OF HISPAN , specify Cuban, Mexica	NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	I or No- 1	I4. RACE - Black,	- American White, etc.	ndlan,	
Β¥	3X Widowed 4 □ Divorced	IF YES, GIVE WAR (OR DATES	10	YES 2 NO Specify	y:		Specify			
	15. DECEDENT'S ED	UCATION	16e DECEDENT	'S USUAL OCCUP	ATION	18b. KIND OF BU	CINICOS (INICI)	IO TOWN	WH	IITE	_
E	(Specify only highest grad Elementary/Secondary (0-12)	le completed)	(Give kind	of work done during use retired.)	most of working	160. KIND OF BU	SINESS/INDU	SINT			
급	12	College (1-4 or 5+)	SALE	SLADY		DEPART	MENT S	STORE	2		
COMPLETED	17. FATNER'S NAME (First, Middle, Last)				16 MOTNER'S NA	ME (First, Middle, Maiden					_
		SM	ITH		PESSIE		OSTRO	FSK	Y		
BE	CERCHON 19e. INFORMANT'S NAME (Type/Print)			NG ADDRESS (Str		Route Number, City or Tow					_
2	MR. IRVIN J. LUS	TMAN				BALTIMORE			5		
1	20. METHOD OF DISPOSITION		20b. PLACE AND DAT				CATION - CI				
	1 Densition 5 Other (Specify)	noval from State	cemetery, crematory of			7 + 7-1995 B					
	21. SIGNATURE OF FUNERAL SERVICE L	CENSEE D	WORKINI	22. NAM	AND ADDRESS OF FA	CILITY		/CE/	מוח		_
- 1	1 0 sall 1	0 7		SOL	LEVINSON	& BROS.,	INC.				
\neg	22 DADE I ENTERNO MANAGEMENT	9	wes	601	O REISTERS	STOWN ROAD	BALTI	MORE	E, MD	212	15
- 1	23. PAR I. Enter the diseeses, or shock, or heert failure.	List only one cause of	used the deeth. Do on each line.	not enter the	mode of dying, such	h es cerdiec or respi	ratory erres	st,	Approx	imata i Betwe	en
- 1	IMMEDIATE CAUSE (Final disease or condition	^	_ 11	11	22	7				and De	
	resulting in death)	· HCUTI	E 101	4000	RUITE	INFARC	Mon	V			
		DUE TO (OR	AS A CONSEQUENCE	OF):							
CERTIFICATION	Sequentially list conditions,	b. DUE TO (OR	AS A CONSEQUENCE	OE).					-		
E I	if any, lesding to immediate cause. Enter UNDERLYING	502 10 (011)	AS A CONSEQUENCE	OF).					ĺ		
윤	CAUSE (Disease or Injury that initiated events	DUE TO (OR	AS A CONSEQUENCE	OF):					-		
E	resulting in death) LAST	4		11.					ĺ		
뜅		0.							+		
EDICAL	PART II. Other eignificent condition		0 -		ling ceuse given in	Part I. 24s. WAS AN PERFOR			WERE AUTOPS		GS
음매	- CONCLESTIVE	HEA	4 5	tilures	A	1 YES 2		0	COMPLETION (OF DEATH?		
ME	- NSULIN	DEPEN-		19861		174			1 YES 2	NO	
	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH	res 🗆 No	☐ UNCERTAIN	4 D					
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DE	ATN (Check only o	ne)						
PHYSICIAN:	1 NES 2 NO	1 Inpetient ,2 ER/	Outpatient 3 DOA	OTHER:	lome 5 🗌 Residence	8 Other (Specify)					
표	27. MANNER OF GEATH	28e. OATE OF INJU (Month, Day, Ye		IME OF 28c.	INJURY AT WORK?	28d. OEŞCRIBE NOW II	NJURY OCCU	REO			
B	Natural 5 Pending Investigation				YES 2 NO						
ا ۵	3 Suicide 6 Could not be	26e. PLACE OF INJ building, etc. (URY — At home, farm Specify)	, street, factory, o	ffice	28f. LOCATION (Street of City or Town, State)	and Number or	Runsi Roc	ute Number,		
	4 Nomicide determined										
7	29a. CERTIFIER (Check only 1 CERTIFYING PNYS	SICIAN: To the best of my k	nowledge, death occu	rred at the time, i	ate end place, end dua	to the cause(s) and mar	mer ee stated	ı.			
COMPLET	one) 2 MEDICAL EXAMIN	ER: On the basis of axamin	ation and/or investiga	tion, in my opinio	n, death occured at the	time, date end place, en	d dun to the	ceuse(e) (end manner e	e stated.	
BEC	296. SIGNATURE AND TITLE OF CERTIFIE	R /			29c. LICENSE NUM	IBER	29d. DATE !	SJGNED (J	Month, Day, Ye	ar)	_
	Harrisen	Halo	han		1) 2859	25	17	Sta	25		
2	30. NAME AND AODRESS OF PERSON WI	O COMPLETED CAUSE OF	11-			1 0		-			
	TASNEEM LAK	1) AM 72	20 /A	RK H	EKAHTI	HVE . B	ALTO	K	1) 212	26	
	31. DATE FILED (Month, Day, Year)	22. REGISTRAN'S S	IGNATURE								
	111 1 1 1995	Jalia di walso	CHARAC								

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Jours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

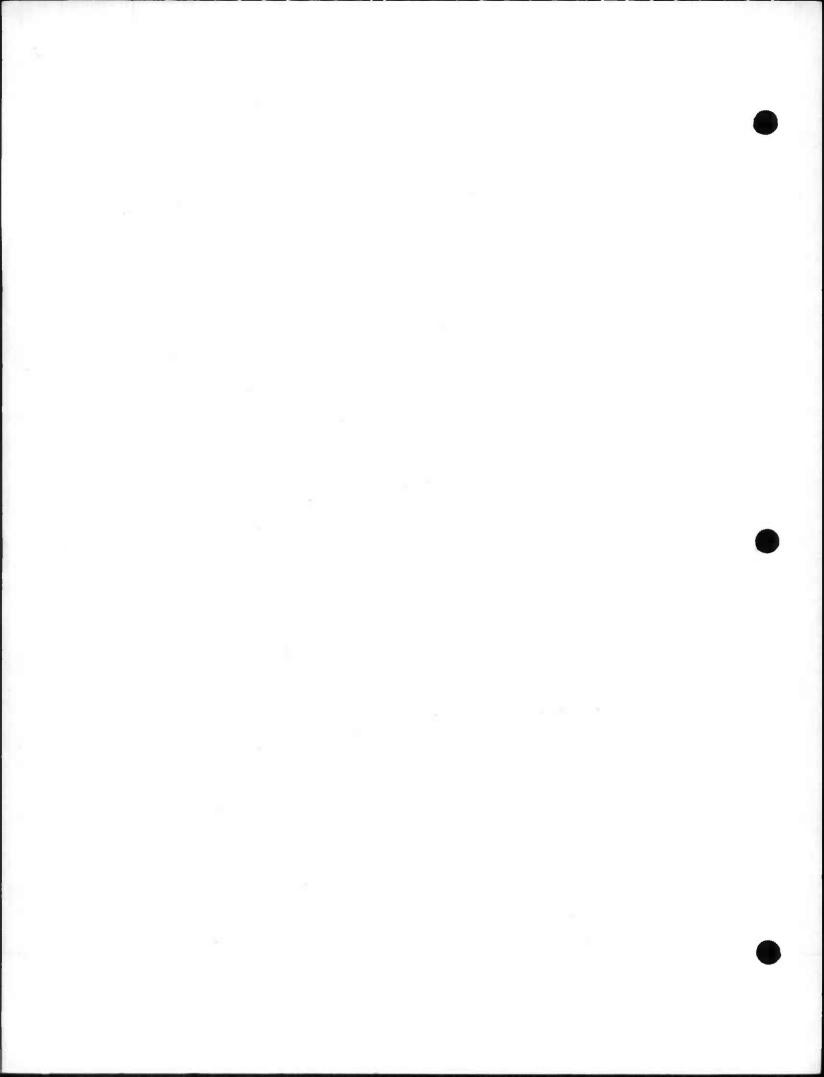
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR 1 -

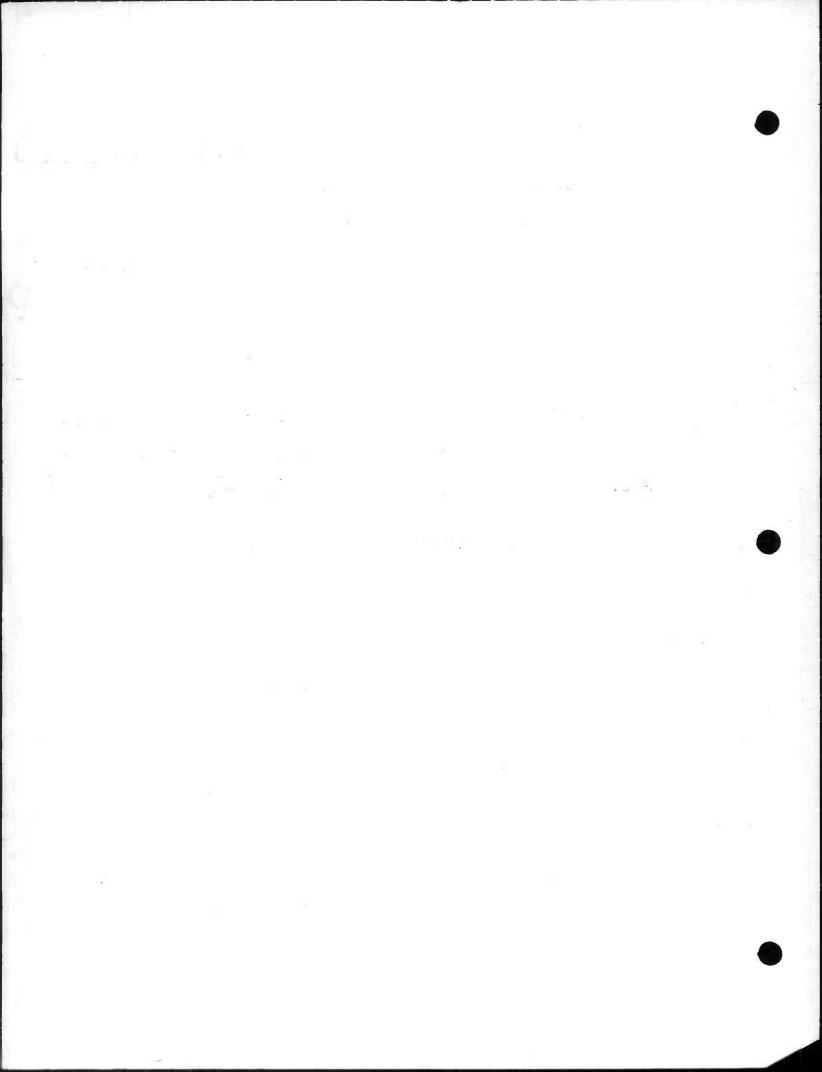
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. REG. NO

	1. DECEDENT'S NAME (First,	Middle, Last)	ne					2. DATE OF MONTH	DEATH DAY	3. TIME OF DEATH				
	4. SOCIAL SECURITY NUMB		1	AGE (In yrs. last birtho			IF UNDER 24 HRS.	7. DATE OF (Month, De	BIRTH	8. BIRTI	HPLACE (State or Foreign			
	463-32-12		1 M 2 DF	87 YR		DAYS	HOURS MIN.	5-13	08	Oodin	TX			
DIRECTOR	98. FACILITY NAME (If not in	vs H	Baltim		9c. C0	OUNTY OF C	n/a							
	10a. STATE	10b. COUNTY		10c.	CITY, TOWN C	R LOCAT	TION				10d. INSIDE CITY LIMITS?			
	MD		N/A		B	alt	imore				1 TES 2 NO			
LONEHAL	10e, STREET AND NUMBER					101	, ZIP CODE		10g. C	ITIZEN OF	WHAT COUNTRY?			
N N	1014 N.	Gilmo	re St.	WED IN U.S. ADMED	Lan		21217				USA			
5	1 Never Merried 2 5		FORCES? 1	YES 2 NOT		if yes, sp	ecity Cuban, Mexic 2 X MD Spec	en, Puerto Rica	Specify Yes or No-	Blac Spec	E — American Indian, k, White, atc. Black			
ם	15. DEC (Specify only	EDENT'S EDUC	ATION completed)	(Give kind	IT'S USUAL OF	CCUPATIO	ON ast of working	16b. Kif	NO OF BUSINESS/	NOUSTRY				
ן צָ	Elementary/Secondary (0	-12)	College (1-4 or 5+)	life. Do NO	OT use retired.)				_					
COMPLE	17. FATHER'S NAME (First, M.	iddle Last)	2 yrs.	HO	me Ma	Ker		AME /First Adiede	Domes Ne. Maiden Surname					
מ ו	McKinsey		vhourn						ockett	,				
E C	19a. INFORMANT'S NAME (7)			19b. MAII	ING ADDRESS	Street a			City or Town, State,	Zip Code)				
-	Gwendoly:	n Brow	vn	10	14 N.	Gi	1more	St. Ba	alto.,	MD	21217			
	20e. METHOD OF DISPOSITE		val from Stata	20b. PLACE AND DA	TE OF DISPOS	ITION /Ne		DATE	20c. LOCATION		own, Stata			
	4 Donation 5 Other	(Specify)		Mt. Z	ion			17/12	Balti	more	MD.			
	21. SIGNATURE OF FUNERA	L SERVICE LICI	ENSEE				es A.		n & Son	& Sons Funeral Hom				
	Jan	er	CV. D	Jollo	0	170	1 Laur	ens St	. Balt	.0.				
	23. PART i Enter the di effock, or he iMMEDIATE CAUSE (Fin disease or condition resulting in death)	eert failure. L ai	DUE TO (OF	on each line.						arreat,	Approximate interval Between Onset and Death			
			Or Co	n n an	E OF):	tes	4 2	rear						
CALION	Sequentially list conditi		DUE TO (OF	AS A CONSEQUENCE	E OF):		,							
	CAUSE (Disease or Inju			R AS A CONSEQUENCE										
כבאווגו	that initieted evente reaulting in death) LAS													
- 11	PART ii. Other aignifice	nt conditions	contributing to de	eth but not resulti	ng In the un	derlyin	g cause given i	Part I. 24	e. WAS AN AUTOPS PERFORMED?	Y 248	. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO			
EDICAL		orna	e an	cargas				1	YES 2 NO		COMPLETION OF CAUSE OF DEATH?			
N L	DID TOPACCO	- HEE C	· Lnd	asterio	rel.	un	(FA F) \L				1 - YES 2 NO			
ž	DID TOBACCO		ONIKIBUTE	IO CAUSE	OF DEA									
	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO	U MEDICAL	HOSPITAL:		OTHER	₹:	ACE OF DEATH (C							
rn tolcian.	27. MANNER OF DEATH		26e. DATE OF IN.	JURY 28b.	TIME OF	28c. INJ	e 5 Residence	_	pecify) IBE HOW INJURY (CCURED				
10	2 Accident	Pending Investigation	(Month, Day,		INJURY M	1 🔲	YES 2 NO		10-0					
		Could not be detarmined	building, atc	NJURY — At home, fa (Specify)	rm, street, fact	ory, ome	•	City or To	Route Number,					
COMPLEIED			CIAN: To the best of my								s) and manner as stated.			
	29b. SIGNATURE AND TITLE	OF CERTIFIER					29c. LICENSE NU				(Month, Day, Year)			
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	30. NAME AND ADDRESS OF													
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	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART CERTIFIC	MENT OF	HEALTH AND I		HYGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) A. SOCIAL SECURITY NUMBER	Elaine	4	FIB	WITZ	2. DATE OF MONTH	e 27 9	ST.	TIME OF DEATH	
	219-48-0489	1 □ M 2 🔀 F 4	9 YRS.	F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.		9,1946	Wash	ACE (State or Foreign	
TOR	Suburban Hospi		1	Bethes	on location of de	ATN	9c. COUNT	t gom		
DIRECTOR	10a. STATE 10b. COUNT	ntgomery		TOWN OR LOCA				100	d. INSIDE CITY LIMITS? YES 2 X NO	
ERAL	6410 Ruffin Roa	ad		10	20815				T COUNTRY?	
BY FUNER	11. MARITAL STATUS 1 Never Married 2XXMarried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 7 NO	If yes, s	CENDENT OF NISPAN pecify Cuben, Mexica S 2 X NO Specify	n, Puerto Ric	Specify Yea or No 1	4. RACE — Black, W	American Indian, Thite, etc. White	
OMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	16a. DECEDENT'S US (Give kind of wo. life. Do NOT use Human R	rk done during moretired.PSYC	chologis	st/co	nceptual		tems	
E COMPL	17. FATNER'S NAME (First, Middle, Last) George Brees		3744110411 21	00042		ME (First, Mid	dle, Melden Sumame)			
TO B	196. INFORMANT'S NAME (Type/Print) Barry LeiboWitz 196. MAILING ADDRESS (Street and Number or Rural Route Number. City or Town, State, Zip Code) 6410 Ruffin Road, Chevy Chase, Md.									
	20a. METHOD OF DISPOSITION 1 (\$\sum_{\text{Surfal}} 2 \sum_{\text{Cremation}} 3 \sum_{\text{Rem}} \text{Rem} 4 \sum_{\text{Donation}} 5 \sum_{\text{Other}} \text{(Specify)} \qquad 21. SIGNATURE OF FUNERAL SERVICE LICE	Ad	PLACE AND DATE OF etery, crematory or othe as Isra	el Cer			Washing			
	Lia D.	William	25	Ives- Falls	-Pearsor Church	Fun VA	eral Home . 22046			
	IMMEDIATE CAUSE (Final	a. CHRCING DUE TO (OR AS A	ich line.					it,	Approximate Interval Between Onset and Death	
CERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):							
MEDICAL CEF	PART II. Other eignificant condition	s contributing to death bu	ut not resulting in	the underlyin	g cause given in		Ba. WAS AN AUTOPSY PERFORMED? YES 2 NO	CO	RE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH?	
AN: ME	DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	F DEATH YES	□ NO □	UNCERTAIN	<u></u>		1[YES 2 NO	
PHYSICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 □ Inpatient 2 XER/Output		THER:	ne 5 🗆 Residence	8 Other (S	ipecify)			
ву РН	27. MANNER OF DEATH 15 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME (Y WO	URY AT ORK? YES 2 NO	28d. DESCR	IBE NOW INJURY OCCU	RED		
ETED	3 Suicide a Could not be 4 Nomicide determined	28e. PLACE OF INJURY building, etc. (Speci	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				ON (Street and Number or lown, State)	Rural Route	Number,	
сомь		CIAN: To the best of my knowled R: On the bests of examination							d menner as stated.	
TO BE COI	296. SIGNATURE AND HIGHE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WIS	Muy O	ATH (ITEM 27) (Topos, P)	rint)	29c. LICENSE NUM	9 G	29d. DATE S	IGNED (Mo	onth, Day, Year)	
	31. DATE FILED (MONTH, Day, Year) JUL 11 1995 JUL	1 .		WOOD	Rb A	RETT	YESDA 1	MB	20817	

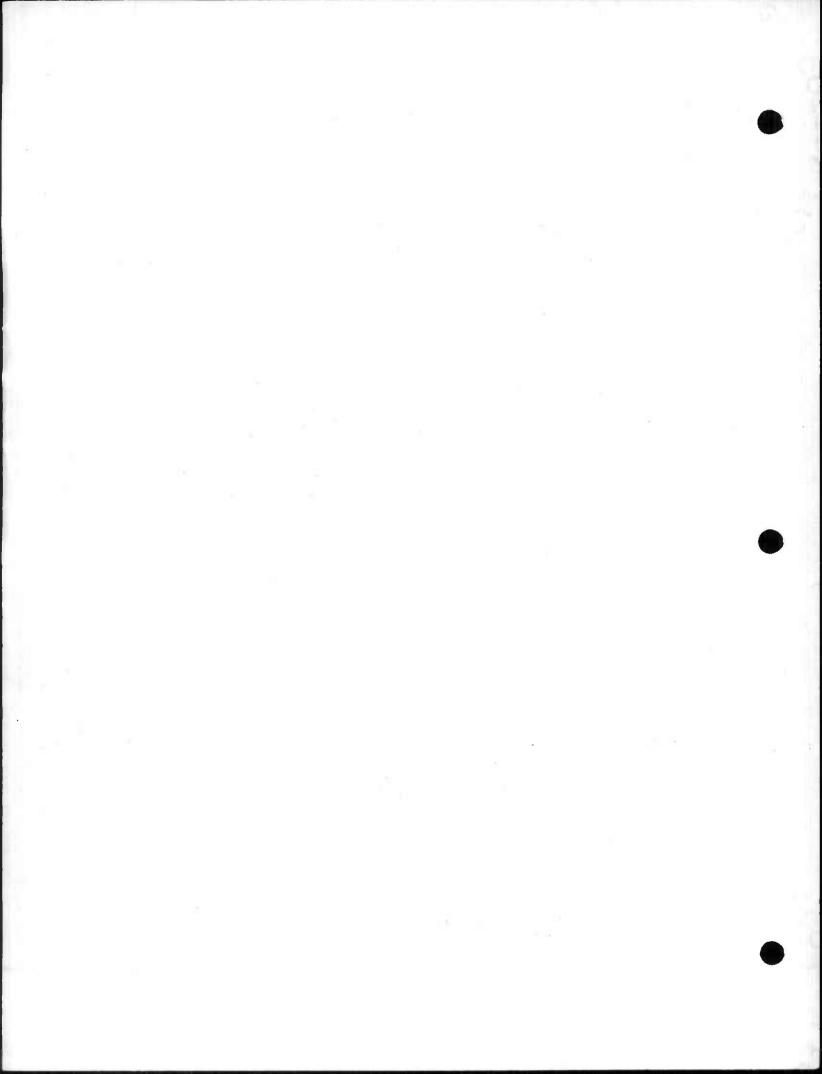


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			CERTIF	ICATE	OF C	DEATH		REG. NO			
1. DECEDENT'S NAME (First, Scott		ARLES	Lac	key			/40	ATE OF OEATH DON'TH DON'TH DON'TH	199	YEAR	3. TIME OF OEATH
4. SOCIAL SECURITY NUMBER 231-49-4006	5, SEX	6. AGE (In yrs. 13	last birthday) YRS.	IF UNDER 1		IF UNDER 24 H	N. SEI	ATE OF BIRTA Forth, Day, Year) PT. 20,1	981	8. BIRTHI Country LENNE	
9a. FACILITY NAME (If not ins Prince Geor RESIDENCE OF DEC	ges Hospital			96. CITY, TO		LOCATION O			9c. COI	UNTY OF OR	
MARYLAND	Anne Arundel	. Co.		Y, TOWN OR OFTON	LOCATIO	ON .					10d. INSIDE CITY LIMITS? 1 YES 2X NO
100. STREET AND NUMBER 2600 TOR CT.						1114					HAT COUNTRY?
11. MARITAL STATUS 1 X Never Married 2	ferried FORCES?	DENT EVER IN U.S. 1 TYES 2 (/E WAR OR DATES	ARMEO NO	If y	S DECEN es, speci	Ify Cuban, Mi	SPANIC OR exican, Pue pecify:	HGIN? (Specify Yes	or No—	14. RACE Black, Specify WHI	— American Indian, White, etc. TE
15, DECE (Specify only Elementary/Secondary (0- 7TH	DENT'S EDUCATION highest grade completed) College (1-4 or	r 5+)	DECEDENT'S (Give kind of ville. Do NOT us	vork done dur se retired.)	UPATION ing most	of working		166. KIND OF BUS		DUSTRY	
17. FATHER'S NAME (First, Mic	die, Lest) COTT LACKEY		- 4		1			rst, Middle, Meiden			
19a, INFORMANT'S NAME (Ty)			196. MAILING			Number or R	ural Route I	PAYNE Number, City or Tow D 21114			
1 X Burlal 2 Cremation 4 Donation 5 Other (2) 21. SIGNATURE OF FONERAL	SERVICE ICENSEE	Hon		NATIO 22. NA MU 110	NAL ME AND IRPH	CEMETADORESS OF FALL	FACILITY LS CH	7-6-95 URCH FU	ARLI NERA S CH	L HOM	, VA.
23. PART I. Enter the district, or he immediate CAUSE (Final disease or condition resulting in death)	art tallure List only one	that caused the cause on each I	ine.		e mode	of dying,	such as o	cardiac or respi	ratory ar	rest,	Approximate Interval Between Onset and Deatl
Sequentially list condition if any, leading to immediate. Enter UNDERLYIN CAUSE (Disease or injurthat initiated events resulting in death) LAST	or de la contraction de la con	TO (OR AS A CON									
PART II. Other significan	conditions contributing	to death but no	t resulting i	n the unde	rlying c	cause giver	in Part I	24s. WAS AN PERFOR	MED?		WERE AUTOPSY FINDINGS MAIL ABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN									□ YES 2 □ HO		
THE RESERVE AND ADDRESS OF THE PERSON NAMED IN COLUMN 1				OTHER:		5 🗆 Resider	ce & 🗆 C	Other (Specify)			
DID TOBACCO US 25. WAS CASE REFERRED TO EXAMBLERY 1. YES 2 NO	HOSPITAL	2 C ER/Outpetlent	3 DOA	e Lu seuraing							
25. WAS CASE REFERRED TO EXAMINER? VES 2 NO 27. MANNER OF DEATH 1 MANNER OF DEATH 2 Accident In 3 Suicide 6 C	HOSPITAL 1 E Impatisent 28s. DATE (Mont benefitig) westingstion putid nat be harmined	2 TER/Outpetlent OF INJURY h, Day, Year) 9, 1995	tome, farme	OF 26	e. INJUR WORK VES	Y AT	201.1	DESCRIBE HOW IT	poet.	HIX	ed:0 bjects



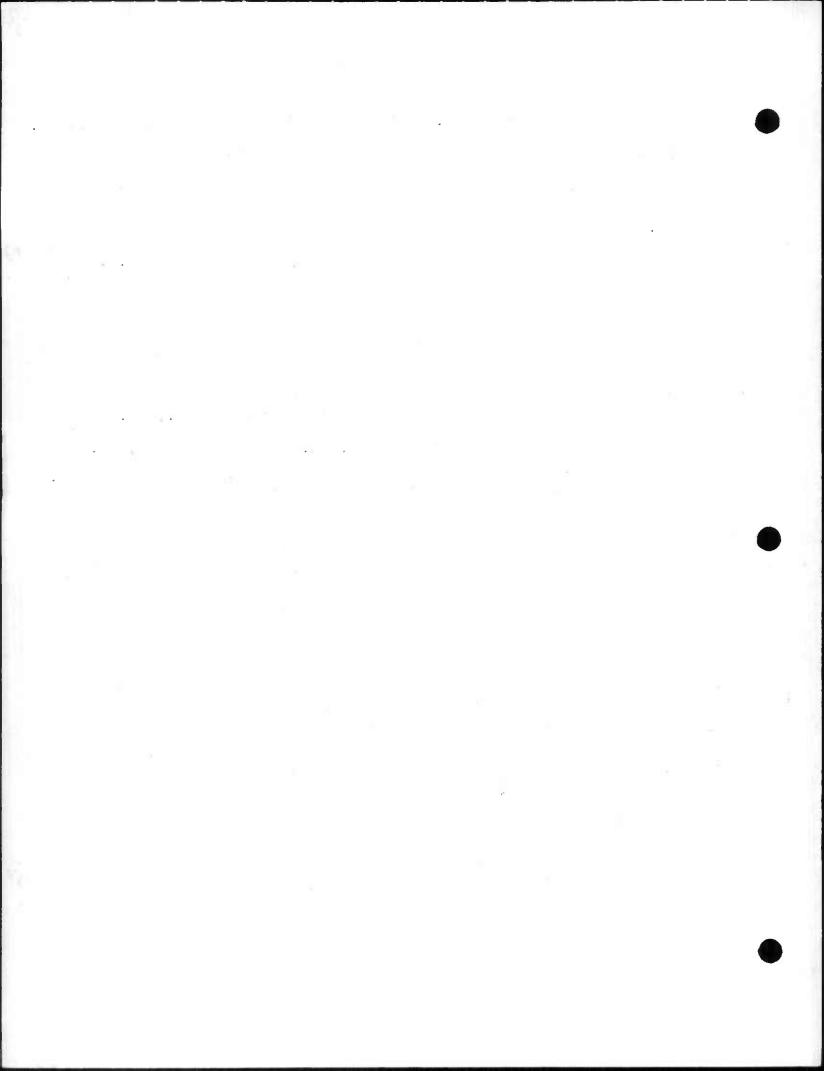
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within mouns after death. Page 6 may be retained by the hospital or attending physician.	IF FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	DRTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be execut	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and or be filed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to buring the with the State Dept.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic	

	FOR STATE REGISTRAR	STATE OF MARYLAN		MENT OF HI			TYGIENE REG. NO.	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF	DEATH	3. TIME OF DEATH
	Theresia	MARTIN				JUL	Y 10, 1	995 2:15 P N
	4. SOCIAL SECURITY NUMBER 5.			IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF (Month, D	BIRTH	6. BIRTHPLACE (State or Foreign Country)
	9a. FACILITY NAME (If not institution, give street	□ M 2 🔀 F 8	7 YRS.	ONTHS DAYS	HOURS MIN.	Oct	2,1905	GERMANY
œ				9b. CITY, TOWN OF	LOCATION OF OR	ATH	100000000000000000000000000000000000000	INTY OF OEATH
DIRECTOR	RIVERVICW NURS	sing Home		1001	7 -			BAltIMORE
RE	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCATION	ON			10d. INSIDE CITY LIMITS?
		Altimore		N.A				1 TES 2 NO
3AL	100. STREET AND NUMBER 1 EASTCRN A			10f.	2122	. 1	10g. CIT	TIZEN OF WHAT COUNTRY?
FUNERAL		WAS DECEDENT EVER IN U.	C ADMED	140 990 0505				U.S.A.
	1 Never Married 2 Married	FORCES? 1 YES	2 NO	If yea, spec	olfy Cuban, Maxica	n, Puerto Rica	Specify Yea or No— n, atc.)	14. RACE — American Indian, Black, White, etc.
ВУ	3 Widowed 4 Divorced	IF TES, GIVE WAR OR DATE	3	1 U YES	2 NO Specify	/:		Specify: White
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con	ION 16	Give kind of wo	rk done durina most	of working	16b, KII	ND OF BUSINESS/INI	DUSTRY
		College (1-4 or 5 +)	Ille. Do NOT use	retired.)		5	ster S	ervants of red Ht of Jesu
MP	17. FATHER'S NAME (First, Middle, Last)	N.A.		NUN				RED Ht of Jesu
	Toka dal	41.0+11			16. MOTHER'S NA	ME (First, Midd	lle, Maiden Surname)	Bad-
BE	19a. INFORMANT'S NAME (Type/Print)	I/FK / //V	195 MAILING A	DDRESS (Street an	d Number or Burel 6	CA-D	City or Town, State, Zin	n Corto
2	TeresA Lea	P	210	11-		AUR	_	1000 MOZIZZI
	20a. METHOD OF DISPOSITION	20b. Pt	ACE AND DATE OF	DISPOSITION (Nam		DATE		City or Town, Slate
	1 N Surial 2 Cremation 3 Remove 4 Donalion 5 Other (Specify)	From State Cornete	CRER H	t ef Je	us Cen	17-13	BAK.	MORE HARYlan
	21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE C	•		ADDRESS OF FA			
	· parles	Loun	erus)	Josep	oh N. 2	annii	no Jr. j St. Ba	Funeral Home
\Box	23. PART Enter the diseases, of com- ahock, or heert fellure. Julii	plicetions that caused the	ne death. Do no	t enter the mod	e of dying, auci	h aa cardiac	or reapiratory ar	rrest, Approximete
	IMMEDIATE CAUSE (Final							Intervel Between Oneet and Death
	diseese or condition a	Cordio		rest				1/2
	N.	DUE TO (OR AS A CO						2 1/2
0	Sequentielly list conditions, b.	DUE TO (OR AS A CO	P DCDA					2-4 94
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	C ARONIC			+ Tuf	estain	e Cn.E	2 m.
띮	CAUSE (Disease or injury thet initiated events	DUE TO (OR AS A CO	INSEQUENCE OF):				0101	
ᇤ	resulting in death) LAST	LANGE		CCRAL	Bedson	re		6 months
2	PART II. Other significant conditions c	ontributing to death but	om A	the underlylag	cause alven in	Bart I 24	e. WAS AN AUTOPSY	2 W CEACS 24b. WERE AUTOPSY FINDINGS
CAI		on a section of the s	not recurring in	the underlying	cause given in		PERFORMED?	AWAILABLE PRIOR TO COMPLETION OF CAUSE
EDI						- 1	TYES 2 T NO	OF DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIB	LITE TO CAUSE OF	DEATH VES		UNCERTAIN			1 TYES 2 NO
IAN	25. WAS CASE REFERRED TO MEDICAL	26.	PLACE OF DEATH		OTTCERIAII	101		
SIC		OSPITAL:		OTHER:	6 Residence	6 Other (S	pecify)	
PHY	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. INJU	RY AT		BE HOW INJURY OC	CURED
BY	1 Natural 5 Pending 2 Accident Investigation				S 2 NO			
8	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, atc. (Specify)	At home, farm, atr	eel, factory, offica			ON (Street and Number own, State)	or or Rural Route Number,
ETE								
됩		N: To the best of my knowled						
COMPLET	2 MEDICAL EXAMINER: C	On the basis of examination as	nd/or investigation,	In my opinion, de	ath occured at the	Jime, data and	place, and due to It	he cause(a) and manner as stated.
BE	29b. SIGNATURE AND TITLE OF CENTIFIED	/ ux			29c. LICENSE NUN	IBER	29d. DAT	TE SIGNED (Month, Day, Year)
10	TO MANY AND ASSESSED AS	3 M.D.			D-14	221		1-10-95
	30. NAME AND ADDRESS OF PERSON WHO C	223 EA	(ITEM 27) (Type, P	rine)	1 B.	14.	4. 41	1-10-95 d. 21221
	1 'N. 1-/NOZZ(66) EA	5TOCKN	MUCNU		TIM	ore M	1 21221
I		32. REGISTRAR'S SIGNATI	IRE					
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATU	IRE					

		1 - STATE REGISTRAR	STATE OF MARYL		ARTMEN IFICATI			MENTAI	HYGIENE REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Lest)	Eunice					Jul	y 08	95	AR	1:30P.M
-				(In yrs. lest birthd	MONTHE		F UNDER 24 HRS.	7. DATE	28-27	4. }	Man Man	ace (State or Foreign Tyland
2, 3 should	OR	9a. FACILITY NAME (If not institution, give streets 557 Laurens St			9b. CIT		LOCATION OF DE	EATH		9c. COUNTY	OF DEAT	
Pages 1,	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c.	CITY, TOWN	OR LOCATION	N .				10	d, INSIDE CITY
permit. Pag			/A				imore				15/	LIMITS? YES 2 NO
isi.	ERAL	100. STREET AND NUMBER 547 Laurens St	reet			100	L217				J.S.	T COUNTRY?
21215-0020 If or attending physician, for use as the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EYER FORCES? 1 YES	2 . NO		If yes, specil	DENT OF HISPAN ly Cuban, Mexica NO Specify	n, Puerto F		or No- 14,	RACE -	American Indian, thite, etc. Black
1215-0 r attending use as the	ED	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION ompleted)	16a. DECEDEN	T'S USUAL O	CCUPATION	of working	16b.	KIND OF BUSI	NESS/INDUST	RY	
	COMPLET	Elementary/Secondary (0-12) 6th	College (1-4 or 5+)	We. Do NO	ruse retired.) ewif	-	ir working		Own H	ome		
# 2 2 X	E CO	17. FATHER'S NAME (First, Middle, Last) Charles Patte	rson			1	Editl		iddie, Maiden S .owden			
; MARYLAND be retained by the hospit ge 5 should be detached e notified at once.	TO B	19a. INFORMANT'S NAME (Type/Print) Leonard Patte	rson				Number or Rural F					1215
RE, may be or, page		20a, METHOD OF DISPOSITION 1 3 Burlal 2 Cremation 3 Ramon	201	D. PLACE AND DA	TE OF DISPOS	ITION (Name	of	DATE	20c, LOC	ATION — City	or Town,	Stota
Page 6 ma al director, p		4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE		Arbutu			ADDRESS OF FAC	CILITY		utus,		
BALTIMO after death. Page 6 by the funeral direct moval.		Vernon Bail		00014	V	ernor	n Bail	ev F	unera	1 Set	cvi	d Ave. ce 21215
BA hery filled in by the nation, or removal.		23. PART i. Enter the disesses, or co ahock, or heart failure. L' IMMEDIATE CAUSE (Final disease or condition resulting in desth)	molications that cause is cally one cause on e	ech line.	o not enter	the mode	of dying, such	h as card	isc or respin	etory srrest,		Approximate interval Between Onset and Death
executed with and complet o burial, crer matic event	z		DUE TO (OR AS	A CONSEQUENCE	E OF):	1						
or to	ATIO	Sequentially list conditions, if any, isading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	CONSEQUENCE	E OF):							
S, P.O. Boddeath certificate attending physiental Hygiene pri	CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST										
0 E S 3		PART II. Other eignificant conditions	contributing to death t	out not resultin	ng in the ur	darlying c	ause given in i	Part I.	24s. WAS AN A			RE AUTOPSY FINDINGS
RECORD requires that the peen signed by the signed by the shows any in	MEDICAL	8							PERFORM	4	CO	MPLETION OF CAUSE DEATH?
		DID TOBACCO USE CONTR	BUTE TO CAUSE C	F DEATH	YES 🔲	10 X	UNCERTAIN	10			1 [YES 2 NO
E 22 E	SICIAN:		HOSPITAL:	26. PLACE OF D	OTHE		Residence					
S F is is E	РНҮ	27. MANNER OF DEATH 1 Netural 5 Pending	26e. DATE OF INJURY (Month, Day, Year)		TIME OF INJURY	28c. INJURY WORKS	AT		(Specify)	JURY OCCURE	0	
TTENDING TOR: After after death 28 is ma	ED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJURY building, atc. (Spe	— At home, fam cify)	m, street, fact		ZANO	28f. LOCA	TION (Street en	d Number or R	ural Route	Number,
RO OR THE	COMPLETE	29a. CERTIFIER (Check only	AN: To the best of my know	ledge, death occ	urred at the t	me, deta and	d place, and due	to the cau	se(s) end mann	er as stated.		
HOSPI FUNER Within TANT:		one) 2 MEDICAL EXAMINER: 29b. \$IGNATURE AND TITLE OF CERTIFIER	On the basis of examination	n and/or investig	ation, in my o	pinion, deati						
TO THE DE FILED IN PORT	TO BE	Oluseg O.	antoli	mi	4) -	7	23	72	4	DJUL	NED (Mo	O, 1995
		30. NAME AND ADDITIESS OF PERSON WHO OLUSEGUN O	·LAWOYI	NM:	D . 20	600/	19ERT	y #	164T	SAKE	BA	LTIMOSER
V		JUL 1 1 1995 Julia	22. REGISTRADS SICK	ATURE						-		
												DHMH-16 Rev 1/89



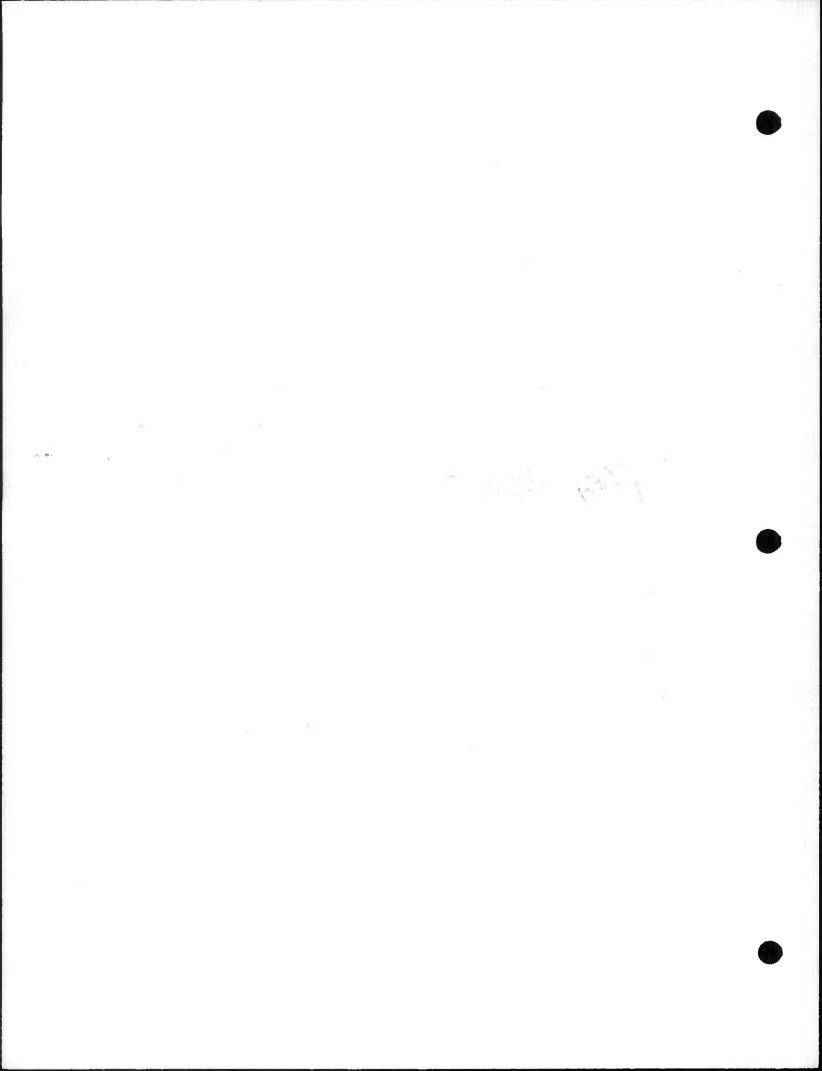
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

L OK ALLENDING PHYSICIANT In law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	. DRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	hours after death with the State Dept. of Health and Mental Hygliene prior to burial, cremation, or removal.	23 shows any injury, or other traumatic event, the medical examiner must be notified at nace.
that the	ed by the	th and Me	any Iniu
requires	been sign	t. of Heaf	Shows
The law	ate has	tate Depr	lem 23
SICIAN	s certifica	th the St	d. or it
NG PH	her this	ath wil	marke
ENDI	DR: At	fter de	80
JH A	MECT	Durs a	ет 2
_	0	2	Ξ

	1 - FOR STATE REGISTRAR	STATE OF MARYLAN		ENT OF HEALTH		TAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)				2. D.	ATE OF OEATH		3. TIME OF DEATH		
	Sister Mary Julie	Maggioni, RS	SM			ulv 6.	W YE	4:20 P. M		
	000 84 0000			MOER 1 YEAR IF UNDER	24 HRS. 7. D/	ATE OF BIRTH forth, Day, Year)	0.8	IRTHPLACE (State or Foreign ountry)		
		1 □ M 2 KMF 83	YRS. MON	THE DAYS HOURS		11y 20,1		GA		
~	So. FACILITY NAME (If not institution, give street	et and number)	9b.	CITY, TOWN OR LOCATI	ON OF DEATH		9c. COUNTY			
DIRECTOR	The Villa			Baltimor	е		В	altimore		
EC	10s. STATE 10b. COUNTY		10c. CITY, TO	WN OR LOCATION				10d. INSIDE CITY		
	Md Balt	imore	В	altimore				LIMITS?		
AL	10e. STREET AND NUMBER			10f. ZIP CODE	E	-	10g. CITIZEN	OF WHAT COUNTRY?		
FUNERAL	6806 Bellona Aven	ue		2121	2			USA		
FU	11. MARITAL STATUS 1 Never Married 2 Married	2. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2		13. WAS DECENDENT O	F HISPANIC OR	IGIN? (Specify Yes	or No — 14, 1	RACE — American Indian, Black, White, atc.		
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES		1 TYES 2 NO		no mount enc.)		Specify:		
	15. DECEDENT'S EDUCAT	TION 16	n. DECEDENT'S USU	AL OCCUPATION		16b. KIND OF BUS	INESS/INCLISTS	white		
ET	(Specify only highest grade co	mpleted) College (1-4 or 5+)	(Give kind of work of life. Do NOT use reti	fone during most of working	ng	TOD. KIND OF BOX	SINESS/INDUSTI	31		
APL.		4+	Religiou	ıs Sister		Catho	lic Chu	ırch		
COMPLETED	17, FATHER'S NAME (First, Middle, Last)				HER'S NAME (Fir	st, Middle, Malden				
BE (Joseph Onorato Mag	ggioni		Ros	salie G	liamas				
2	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADD	RESS (Street and Number	or Rural Route A	lumber, City or Town	n, State, Zip Code	9)		
-	Sisters of Mercy		6806 Be	ellona Aver	nue, Ba	lto, Md	. 2121	.2		
	20e. METHOD OF DISPOSITION 1 Burlel 2 □ Cremetion 3 □ Remove	I from State cometer	ACE AND DATE OF DIS	lecel	0	ATE 20c. LO	CATION — City of	or Town, State		
	4 Donation 5 Other (Specify) 21. SIGNATUR OF FUNERAL SERVICE LICEN	Car	tholic Ce	emetery	7	/10 Sav	annah.	Ga.		
	12000.	1/	_	Sterling A		Funoral	II.			
	Mally V	Carles		736 Edmond	Son Av	enue R	ofto M	d. 21228		
z	Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death BMEDIATE CAUSE (Finel disease or condition resulting in death) Due TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF):									
MEDICAL	PART II. Other significant conditions of the con	duy di	seas	_		24s, WAS AN PERFOR 1 YES 2	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
AN	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH (C		ERTAIN					
PHYSICIAN:	EXAMINER?	IOSPITAL:	OT	HER:	aldane: C C =	About 10 H :				
H	27. MANNER OF DEATH	28a. DATE OF INJURY	28b, TIME OF	Nursing Home 5 Re		ther (Specify) DESCRIBE HOW II	JURY OCCURE			
ВУР	1 Natural 5 Pending	(Month, Day, Year)	INJURY	WORK? 1 YES 2] NO					
	2 Accident investigation 3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY — A building, etc. (Specify)	At home, farm, street	factory, office	28f, L	OCATION (Street a City or Town, State)	nd Number or Ru	rel Route Number,		
COMPLETED		IN: To the best of my knowledge								
ğ	2 MEDICAL EXAMINER:	On the basis of examination and	d/or investigation, in	my opinion, death occur	ed at the time, d	ata and placa, and	d due to the cau	se(s) and manner as stated.		
H H	296, SIGNATURE AND TITLE OF CERTIFIER	one hus		29c. LICE	639		PAGE DATE SIG	6 97		
2	MANCIA PPRSON WHO C	OMPLETED CAUSE OF DEATH	(ITEM 27) (Type) Print)	fault	Place	POX	3#4	-03		
	31. DATE FILED (Month, Day, Year)	REGISTRAR'S SIGNATO	odsk.							



פאסווווופן וופאי מפ וומווופת פו מוופי.	
examiner must be notified at once.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at onee.
ie.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
he funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1, 2, should
r death. Page 6 may be retained by the hospital or attending physician,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI			MENTAL HYGIEI			
	1. DECEDENT'S NAME (First, Middle, Last)	Faul W				2. DATE OF DEATH MONTH	DAY	YEAR 3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER	Esther M.		F UNDER 1 YEAR	IF UNDER 24 HRS.	July 10,	1995	7- 75 M	
		10 H 20 C		ONTHS DAYS	HOURS MIN.	(Month, Dey, Year)		B. BIRTHPLACE (State or Foreign Country)	
	9a. FACILITY NAME (If not institution, give str			b. CITY. TOWN O	R LOCATION OF D	Nov 8, 19		Maryland Y OF DEATH	
DIRECTOR	Carroll County General Hospital Westminster Carroll								
REC	10a. STATE 10b. COUNTY		10c. CITY, 1	TOWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?	
0		N/A	Balt	imore				TYPES 2 NO	
FUNERAL	10e. STREET AND NUMBER			101.	ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?	
NE	3502 Beech Aven	12. WAS DECEDENT EVER IN			212		U.S.		
BY FU	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	U.S. ARMED 2- NO ATES	13. WAS DECI	cify Cuban, Maxica	NIC ORIGIN? (Specify Year, Puerto Rican, etc.) y:	s or No—	4. RACE — American Indian, Black, Whita, etc. Specify:		
	15. DECEDENT'S EDUC	Allion	16a. DECEDENT'S US	HAL OCCUPATIO	N.	16b, KIND OF BU	ICALIFOR WARLE	White	
E	(Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give kind of work life. Do NOT use n	k done during mos	t of working	100. KIND OF BE	SINESS/INDU	SIRT	
4	10	ounege (1-4 of 5 4)	Homemaker	:		own ho	ome		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Maide	Sumame)		
BE (John Carter				Helen	Heines			
5	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AC	DRESS (Street ar	nd Number or Rural I	Route Number, City or Tox	vn, State, Zip C	ode)	
	Helen Schultze		3919 Bi	ittany	Lane H	ampstead,	Maryla	and 21074	
	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Ramon	val from State cam	PLACE AND DATE OF I	nlecel		1		ty or Town, Stata	
	4 ☼ Donation 6 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	Lo	orraine Pa	rk Ceme	etery 7	/13/95 Bal	timore	e, Maryland	
	21. SIGNATURE OF FUNERAL SERVICE LICE	1-6	\sim	A. Ala	an Seitz	, Jr. Fune	eral Ho	ome	
	M. Man	Deck!	n	3818 1	Roland A	ve., Balti	lmore,	Maryland 21211	
	23. PART I. Enter the diseases, or co shock, or heart fallure. L	mplications that caused ist only one cause on er	the deeth. Do not ach line.	enter the mod	de of dying, suc	h aa cerdiac or reap	iratory arrea	Approximata	
	IMMEDIATE CAUSE (Final			2.	_			Onset and Death	
	disease or condition resulting in death)	1(45/	many	FAI	LULE		_	404-5	
	OUE TO (OR AS A CONSEQUENCE OF):								
ON	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):								
Ä	If any, leading to immediate cause. Enter UNDERLYING	557,57350177						i'	
Ĕ	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):						
CERTIFICATION	resulting in death) LAST	<u></u>							
	PART II. Other algolificant conditions	contributing to death b	ut not resulting in t	the renderteden	anuna eluan la	Bank Lawrence			
CAL	<u> </u>	continuently to death be	at not resulting in t	me underlying	canse diven in	Part I. 24a, WAS A! PERFO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
EDI						1 TYES	2 7 10	OF DEATH?	
Σ	DID TOBACCO USE CONTR	RUTE TO CAUSE O	E DEATH VEC	Пиоп	LINICEDTAIN			1 TES 2 NO	
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH (UNCERTAIN	<u>ч Ц Г</u>			
Sic		HOSPITAL:	0	THER:	& C Pacidana	6 Other (Specify)			
Ä	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME O	F 28c. INJU	PRY AT	28d. DESCRIBE HOW	INJURY OCCU	RED	
ВУР	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR		RK? ES 2 NO				
	3 Suicida 6 Could not be	28a. PLACE OF INJURY building, atc. (Speci	— At home, farm, stre-	et, factory, offica		28f. LOCATION (Street	and Number or	Rural Route Number,	
=	4 Homicide determined					City or Town, State			
COMPLETED	29a. CERTIFIER Check only	AN: To the best of my knowle	edge, death occurred a	it the time, data a	and place, and due	to the cause(s) and ma	nner as stated.		
OM								ceuse(a) and manner as stated.	
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	O ATTS	walke 1	Hzcv	29c. LICENSE NUM	IBER	29d. DATE S	SIGNED (Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	NTH (ITEM 27) (Type, Pri	nt) 21 4	0/67	0 04 11	10		
	WA COCHY	au, 1410.	846 U	156	s pries,	Bels, N	197	2//	
	JUL 1 1 1995 Juli	22. REGISTRAR'S SIGNA	LL LL						

		REGISTRAR		CERTIF	IVAL UI		REG. NO		
		1. DECEOENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
_		Carlo	DUDTA				MONTH DA	AY YEA	AR
	1	Scott	DUBIN		Mazer		July 0		
		4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, West)	8. B	HRTHPLACE (State or Foreign ountry)
_		218-96-1479	1 K M 2 🗆 F	19 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) Mar. 24,	1976 M	aryland
3 should	1 1	9e. FACILITY NAME (If not institution, give	street and number)		9b. CITY, TOWN (OR LOCATION OF DE		9c. COUNTY (
ري دي	<u>«</u>	1212 K B	3 11 110						
2	1 일	4313 Knox Roa	id # 112		Collec	ge Pai	<u>ck</u>	Princ	e Georges
S	DIRECTOR	10a. STATE 10b. COUNT	ry	10c CIT	Y, TOWN OR LOCAT	TION			to a major arms
Ž	<u>=</u>			100.01					10d. INSIDE CITY LIMITS?
E.			Baltimore		Owing	gs Mills			1 X YES 2 NO
ped	N N	10e. STREET AND NUMBER			101	f. ZIP COOE		10g. CITIZEN	OF WHAT COUNTRY?
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5-0020 ending physician. as the burial-transit permit. Pages 1, 2,	FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMEO	13 WAS DEC		IC ORIGIN? (Specify Yes		RACE — American Indian,
215-0020 attending physic		1 Never Married 2 Merried	FORCES? 1 YES	2 XNO	If yes, sp	ecify Cuben, Mexicer	n, Puerto Rican, etc.)	14.	Black, White, etc.
00 00 00	B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES	1 🗌 YES	NO Specify			Specify:
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RYLAND ed by the hospit uld be detached	Ш	Jerald	Mazer	•		4 /			
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-trannoitfled at once.	1 1 1	19e. INFORMANT'S NAME (Type/Print)	Mazer			Brenn		Wexl	
MAR retained 5 should	임						loute Number, City or Town		1
E, N		Mr. Jerald	Mazer	2 Dan	delion (Court Owi	ngs Mills	, MD 21	117
The sage to		20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Ref	20t	. PLACE AND DATE O	F DISPOSITION (Ne			CATION - City of	
OR HOR		4 Donation 5 Other (Specify)	noval from State cen	Har Sina	her place)	7-	6-1995 Owi	inas Mi	11s. MD
Age dire		21. SIGNATURE OF FUNERAL SERVICE L							110/110
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BALTIMORE, I nours after death. Page 6 may be d in by the funeral director, page 4 or removal.		- winsu	e delle	noon					ORE, MD 21215
		23. PART i. Enter the disesses, or	complicatione that cause	d the daeth. Do n	ot enter the mo	de of dving, such	as cerdiec or resol	retory errest	Approximate
filled in b ion, or rer		shock, or heart fellura.	List only one cause on e	ach line.		ac or cynig, such	. se cordiec or reap	ratory streat,	Interval Between
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李章		disease or condition			. 10 /200				
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within 14 within 14 mpletely fille cremation, went. the	1 1	resulting in death)	n. DUE TO (OR AS A	CONSEQUENCE OF	ing				
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JIVISION OF VITAL RECORDS, P.O. BOX 687 OR ATENDING PHYSICIAN: The law requires that the death certificate be executed IMECTOR: After this certificate has been signed by the attending physician and contours after death with the State Dept. of Health and Mental Hydiene prior to burial, em. 28 is marked, or telem 23 shows any Inlury, or other traumatitic and the property of the programments.	BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	Sequentisity list conditions, if sny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition DID TOBACCO USE CONTEST IN TOWN IN THE SIGNIFICANT IN THE SIGNIFIC	DUE TO (OR AS A C. DUE TO (OR AS A d. INSCRIBUTE TO CAUSE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Special Control of the bests of examination of the best o	A CONSEQUENCE OF A CONSEQUENCE OF DEATH YE 28. PLACE OF DEATH 28b. TilM 18d. 28b. TilM 28b. Ti	n the underlying S NO H (Check only one) OTHER: 4 Nursing Hom Nursing Hom I Nursing Hom A 1 Nursing Hom A 1 Nursing Hom Nur	UNCERTAIN SE Residence (URY AT MKY (ES 2) NO end piece, end due to esth occured at the to	PERFOR 1 YES 2 3 Other (Specify) 28d. DESCRIBE HOW II SUPPLIED TO TOWN, Steel of City or Town, Steel 28f. LOCATION (Streel of City or Town, Steel) 3 3 0 0 the cause(s) end men ime, date end place, end BER	NJURY OCCURET A D D D D D D D D D D D D D D D D D D	AWILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1/50 YES 2 NO Part of Power Number, AP 1 2 Se(s) end manner as stated, NED (Month, Day, Year)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 bours after death with the State Dept. of Heath and Mental Hygiene prior to removal or removal and applications or the property of the market and latence and l

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	TIEGIOTHAN				JAIL OF	DEATH	Mt.	EG. NO.	
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF D	EATH	3. TIME OF DEATH
1	Elinor	R. Mill	ler				July 6	, 1995	1:16 P.M
	4. SOCIAL SECURITY NUMBER	5. SEX 6	AGE (In yrs. last	birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	7 DATE OF B	OTH	A RIPTHEL ACE (Chate or Families
	283 40 0965	1 M 2 XF	85	YRS.	IONTHS DAYS	HOURS MIN.	July 2	7 100	9 Tennessee
	9a. FACILITY NAME (If not institution, give	etreut and number)	0.5	7 504	N. OUTY TOWN	OR LOCATION OF			
l cc				1		-	DEATH		COUNTY OF DEATH
DIRECTOR	Northwest Hospita	1			Randal	lstown			Baltimore
입	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION								
<u>=</u>									10d. INSIDE CITY LIMITS?
	Md.	Carroll (County	S	ykesvil				1 TES 2 NO
₹	10e. STREET AND NUMBER				10	. ZIP CODE		10g.	CITIZEN OF WHAT COUNTRY?
	7200 Third Av	enue				21784			U.S.A.
5	11. MARITAL STATUS	12. WAS DECEDENT E					ANIC ORIGIN? (Sp		- 14. RACE - American Indian, Black, White, atc.
BY FUNERAL	1 Never Married 2 Married	FORCES? 1		0		ecify Cuban, Max 2 NO Spe	can, Puarto Rican,	etc.)	Black, White, atc. Specify:
	3 🖾 Widowed 4 🗌 Divorced					- 63			White
COMPLETED	15. DECEOENT'S EDU (Specify only highest grade		16a. DEC	EDENT'S U	SUAL OCCUPATION	DN	16b. KIND	OF BUSINESS	S/INDUSTRY
l lin	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT use	rk done during mo retired.)	ist of working			
1 4	H.S.	+4	HOr	memak	er		D	omesti	C
COM	17. FATHER'S NAME (First, Middle, Last)					18 MOTHER'S	NAME (First, Middle,	Maiden Cume	
e o	Lee Miller Ros	S				Luci	-	eorge	,,,,,
B B	19a. INFORMANT'S NAME (Type/Print)		T						
TO BE	Mr. David L. Mill	on (Cont					al Route Number, Ch		
		er (30Hy	13	8 HIC	kory Pi	ace New	Provide	ence,	RI 02911
	20a, METHOD OF DISPOSITION 1 M Burial 2 Cremation 3 Ram	oval from State	20b. PLACE AI	ND DATE OF	DISPOSITION (NO	ime of	DATE	20c. LOCATIO	N — City or Town, Stata
Ē	4 Donation 5 Other (Specify)		Spring	g Gro	ve Ceme	tery 7	/10/95	Cinci	nnati, OH.
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE			22. NAME A	ND ADDRESS OF			
	V/2. 71	Ylainth					ight Fu		
	Hamy W.	MUNIT	/		P.O.E	ox 195	Sykesvi	lle, M	d. 21784
	23. PART i. Enter the diseases, or ahock, or heart failure.	complication that c	eused the dea	th. Do no	t enter the mo	de of dying, s	ich se cardiac d	or respiratory	
	IMMEDIATE CAUSE (Finsi		_						interval Between Onaet and Death
	disease or condition resulting in death)	•	THE RAS A CONSECU	IIME	NIA				
	Toodking in cookin	DUE TO (OI	R AS A CONSECU	UENCE OF):	,,,,,,				
			COER	POV	A 11</td <td>1 AR A</td> <td>NTIA L</td> <td>711</td> <td></td>	1 AR A	NTIA L	711	
CERTIFICATION	Sequentisity list conditions, if any, leeding to immediate	DUE TO (OI	R AS A CONSEQU	UENCE OF):	n sw	51110		. ~ 1	
ĭ ₹	cause. Enter UNDERLYING	HY	PERT	FAIS	INN	FCGE	UTIAL		
	CAUSE (Disease or injury that initiated events	DUE TO (OI	R AS A CONSECU	JENCE OF):	1010	0 // (
	resulting in deeth) LAST								
		d							
	PART ii. Other aignificent condition	ns contributing to de	sth but not re	suiting in	the underlyin	g ceuse given	n Part i. 24a.	WAS AN AUTOF	
EDICAL								PERFORMEO?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
							¹ 🗆	YES 2 NO	OF DEATH?
2	717 777 477 477 477								1 TYES 2 NO
PHYSICIAN:	DID TOBACCO USE CONT	KIBUTE TO CAUS				UNCERTA	IN K		
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE		(Check only one)	-			
S	1 TYES 2 NO	1) inpatient 2 🗆 E	R/Outpatient 3			e 5 🗆 Residenc	6 Other (Spe	clfy)	
T E	27. MANNER OF DEATH	26a. DATE OF IN. (Month, Day,		26b. TIME (OF 28c. INJ	URY AT	26d. DESCRIBE	E HOW INJURY	OCCURED
BY	1 Natural 5 Pending 2 Accident Investigation	(Mornin, Day,	routy	INJUN		ES 2 NO			
	3 Suicide 6 Could not be	26e. PLACE OF II	NJURY — At hom	e, farm, stre	et, fectory, offic		28f. LOCATION	(Street and Nu	mber or Rural Route Number,
8 E	4 Homicide determined	building, etc	: (Specify)				City or Tow	n, State)	20 1 100 Hz 24 1 1 1 1 1
COMPLETED	29a, CERTIFIER								
<u>-</u>		ICIAN: To the best of my							
Ö	2 MEDICAL EXAMINE	R: On the basia of axad	ination and/or in	vestigation,	In my opinion, d	eath occured at the	ne time, data and p	place, and due	to the cause(s) and manner as stated.
Ш	29b. SIGNATURE AND TITLE OF CERTIFIE	10				29c. LICENSE N	UMBER	29d.	DATE SIGNED (Month, Day, Year)
	/(Men /	ul.	MD		D27	157	>	JUW 6. 1995
12	30. NAME AND ADDRESS OF PERSON M	O COMPLETED CAUSE	OF DEATH (ITEM	27) (Type, Pr	rint)		1		0)1110
	RAYNOLD	Del-	200	3	NA C	THUS	7T U.	CDS.	L CENTER
	31. DATE FILEO (Month, Day, Year)	1.32. REGISTRAR'S	SIGNATURE	,	1001	-IHWE	51 HC)>T//F	IL CENIER
	- I artis - Inco (mornit, Day, 1981)	Jan Manis I HAR'S	SIGNATURE						
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DIVISION	
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31. DATE FILED (Month, Day, Year)
JUL 11 1995

1 -REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Dorothea PENNINGTON July 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 10-14-1896 IF UNDER 1 YEAR 6. BIRTHPLACE (State or Foreign DAYS HOURS BAIN 136-22-5221 98 1 M 2 KF RHODE ISLAND Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR KESWICK BALTIMORE N/A RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND N/A BALTIMORE permit. 1 YES 2 NO 10a STREET AND NUMBER 10f. ZIP CODE FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 700 WEST 40TH STREET U.S.A. 21211 burial-transit 12. WAS DECEDENT EVER IN U.S. ADMED attending physician. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Guben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Married 2 Married Specify: WHITE BY 3 Widowed 4 Divorced use as the 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade 0 COMPLET the funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5 +) the hospital 2YRS. HOUSEWIFE HOMEMAKER once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname notified at ROBERT G. H. be retained by PENNINGTON CAROLINE THEOBALD 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 DOROTHEA N. HORSFALL 1055 WEST JOPPA RD. TOWSON, MD. 21204. pe Page 6 may 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must DRUID RIDGE CEMETERY 7/95 PIKESVILLE, MD. medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY illiam HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212. 23. PART I. Entar the diseases, or complicatione that ceuead the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, and completely filled in by burial, cremation, or remo Approximate shock, or heart fallure. List only one cause on each lina. Interval Between **Onast and Desth IMMEDIATE CAUSE (Finel** the Rheumania disesse or condition 24 hours resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, prior to DUE TO (OR AS A CONSEQUENCE OF) the attending physician Mental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in deeth) LAST 0 Injury, PARTAIL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE health and N MEDICAL 24a. WAS AN AUTOPSY Cerebro- was aular disease with heatpry 1 TES 2 NO OF DEATH? purch Strokes 1 YES 2 NO has been s Dept. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2 NO 26. PLACE OF DEATH (Check only one) r this certificate h h with the State [HOSPITAL 1 | Inpetiant 2 | ER/Outpetient 3 | DOA Homa 5 ☐ Residence 6 ☐ Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY marked, 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident Pending Investigation M L DIRECTOR: After the 2 hours after death w 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 99 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 200 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner ea stated. FUNERAL I = TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: 1 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE In Icabelle Tour Duly 7,1995 M Icabelle TOWN GOMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 0

M. ISABELLE MACGREGOR, KESWICK, 700W . 40 Yh ST BALTIMORE, MD 21211

22. PEGISTHAR'S SHATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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BALTIMORE, MARYLAND 21215-0020	s after death. Page 6 may be retained by the hospital or attending physician.	by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should emoral.	dical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

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FOR STATE REGISTRAR		STATE OF I	MARYLAND	/ DEPARTI	MENT OF	HEALTH AND	MENTAL HYGIEN			
1. DECEOENT'S NA	ME (First, Middle, Last)						2. DATE OF DEATH		3.	TIME OF DEATH
	HENRY	A. NEVR	KLA				JULY 4	,1995	5 ^{YEAR} 7	:30 A M
4. SOCIAL SECURI 349-01-		5. SEX 1 M 2 F	6. AGE (in yrs. in		F UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day Year) Sept. 15,1	915	0. BIRTHPLA	CE (State or Foreign
	(If not institution, give	street and number)	· ·	9	b. CITY, TOWI	OR LOCATION OF D			ITY OF DEATH	
5 13	320 RIVE	R ROAD			PASA	DENA		ANI	NE AR	UNDEL
RESIDENCE C	F DECEDENT			T soo CITY :	man on Loc	ATION				
	Maryland Anne Arundel Pasadena Pasadena 10d. INSBE 21 □ VES 21 □ VES 21 □							LIMITS?		
10. STREET AND, 1320 RI	106. STREET AND NUMBER 1320 River Road 107. ZIP CODE 21122 109. CITIZEN OF United									
11. MARITAL STATU 1 Never Merried 3 Widowed 4	2 Merried	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2	MED	II yes,	ECENDENT OF HISPA specify Cuben, Mexic S 2 NO Spec	ANIC ORIGIN? (Specify Yes, Puerto Ricen, atc.)	or No-	14. RACE — / Black, Wh Specify:	American Indien, lite, etc. White
	15. DECEDENT'S EDU		16e. D	ECEDENT'S US	UAL OCCUPA	TION	16b, KIND OF BU	SINESS/INDI	USTRY	
Elementary/Sec	ecify only highest grad endary (0-12)	College (1-4 or 5)	Give kind of world B. Do NOT use n						
12		2	Ele	ectroni	ic Eng	ineer	West	ingho	ouse	
Elementary/Sect 12 17. FATHER'S NAME HAPPY		7)	NIc	ov mela la		16. MOTHER'S N	AME (First, Middle, Maider	Surneme)		
Henr	У	Α.	INE	evrkla			Unkown			
190. INFORMANT'S Mrs. Pen	name (Type/Print) ny Bates		15	L75 Ket	DORESS (Street)	Road Pas	Route Number, City of Toy sadena, Mar	n stete Zip. Ylanc	f ^{oode)} 211	22
20 METHOD OF D 1 Donetion 5	remetion 3 - Ren	noval from State	20b. PLACE	AND DATE OF I	DISPOSITION (Name of Park	7/7/95 Gle	en Bur	nie,	Maryland
21. SIGNATURE OF	FUNERAL SERVICE LI	chisee dinuical			22. NAME	AND ADORESS OF F				21122
23. PART I. Enta shoo iMMEDIATE CAU disease or cond resulting in deal	r the diseases, or k, or heart fellure. SE (Final Ition	complications that List only one cau	ce Inl	nalak	antar tha n	oda of dying, su	ch as cerdiac or resp	lretory arre	est,	Approximata Interval Between Onset and Death
		OUE TO	(OR AS A CONSE	OUENCE OF):				0		
Sequentially list	immediata	b. OUE TO	(OR AS A CONSE	OUENCE OF):						
Sequentially list if any, leading to cause. Enter UN CAUSE (Disease that initiated ever resulting in deat	or Injury	cOUE TO	(OR AS A CONSE	OUENCE OF):						
<u> </u>		d								
PART II. Other a	Resus Cl		death but not				Part I. 24a. WAS AN PERFOI	RMED?	CON OF E	E AUTOPSY FINDINGS LABLE PRIOR TO IPLETION OF CAUSE DEATH?
DID TOBAC	CO USE CONT	RIBUTE TO CA	USE OF DEA	TH YES		UNCERTAI	N DY		15	YES 2 NO
25. WAS CASE REFE				CE OF DEATH			TY JAL			
EXAMINER?	NO	HOSPITAL:		0	THER:		8 Other (Coasts)			
27. MANNER OF DE	R OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED									
1 Netural 2 Accident	5 Pending Investigation		19, 19ar) 195	710 A		YES 2 NO	_			
3 Suicide	6 Could not be	28e. PLACE O	F INJURY — At he	ome, ferm, stre	et, factory, off	Ice	281. LOCATION (Street	and Number o		
LI 4 Homicide	determined	ounding,		OME			City or Town, State)		ROAD	PASADE
29e. CERTIFIER (Check only one) 2	CERTIFYING PHYS	ICIAN: To the best of			it the time do	ta and place, and du	to the cause(e) end me			
(Check only one) 2							e to the cause(e) end me e time, date end piece, er			Manner ee stated
296 SIGNATURE AN	TITLE OF CERTIFIE			•						
a Sidnatone	A	101 1	(4.5			29c. LICENSE NU			SIGNEO (Mon	
30 NAME AND ADD	mun ff	OCCUPLETED CAUS	MD	***		OCME		JU	ILY O	5,1995

Baltimore,

32. REGISTRAR'S SIGNATURE

31. DATE FILEO (Month, Day, Year)

JUL 1 1 1995

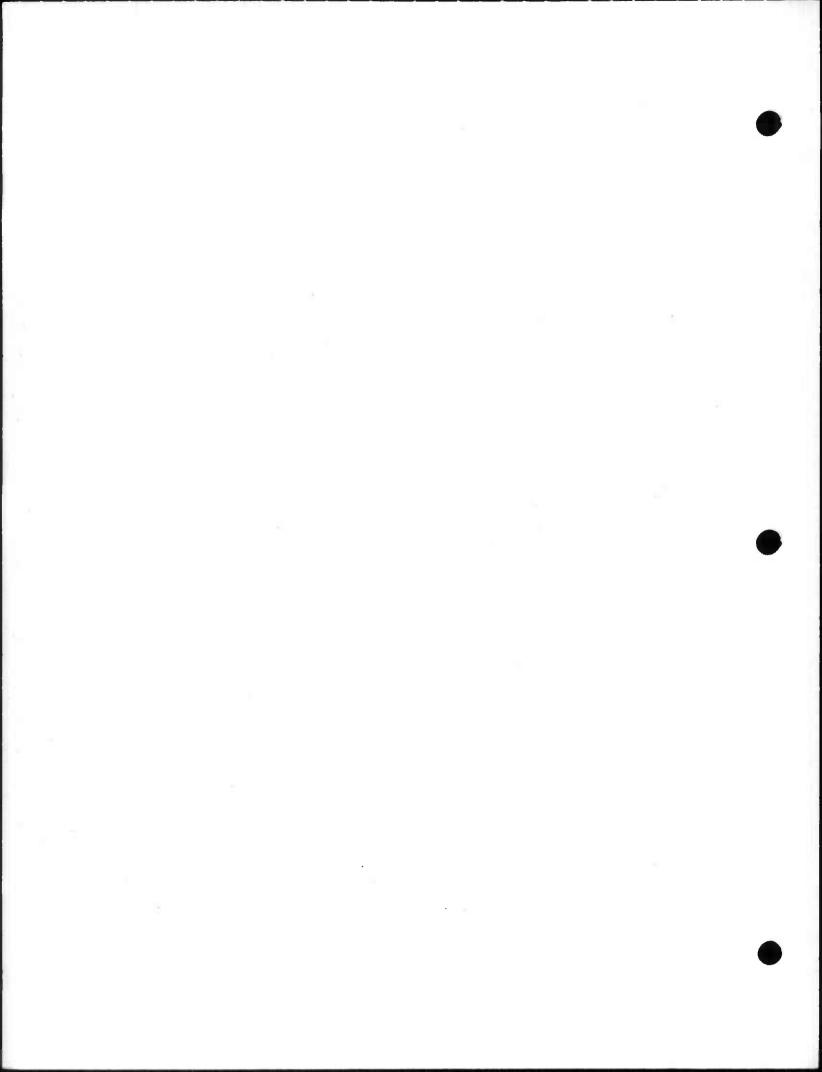
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	í
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		1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.	
		1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. 1	TIME OF DEATH
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGF (in we lost highland) ETHINGS 1 YEAR STRUME 7 DATE OF BUTTLE	8:04 P M
pin		212-48-5319 IX M 2 DF 46 VRS. MONTHS DAYS HOURS MIN. Aug. 13, 1948 Marry	land
020 physician. burial-transit permit. Pages 1, 2, 3 should	OR O	9a. FACILITY NAME (If not institution, give attreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Franklin Square Hospital Center Rossville Baltimore	
ges 1,	DIRECTOR	RESIDENCE OF DECEDENT	I, INSIDE CITY
if. B			LIMITS? YES 2 X NO
1. ansit peri	FUNERAL	100. STREET AND NUMBER 101. ZIP CODE 102. CITIZEN OF WHAT 21221 U.S.A.	COUNTRY?
20 nysiciau	ş	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No.— If yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. RACE —/ Black, WY	American Indian,
21215-0020 I or attending physic for use as the burial	BY	3 Wildowed 4 Divorced 1966-1970 1 YES Wildowed 5 Divorced 1966-1970	hite
or atte	IEC	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY (Since kind of work done during most of working life. Do NOT use retired)	
ID 2. ospital o	COMPLETED	12 College (1-4 or 5+) College (1-4 or 5+) Press Man Printing Compa	ny
MARYLAND 21215-0020 retained by the hospital or attending physician, 5 should be detached for use as the buriat-tran notified at once.			
MAR retained 5 should notified	TO BE		21213
BALTIMORE, I after death. Page 6 may be to the funeral director, page increa.		20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION City or Town, 140 Burlei 2 Cremetton 3 Removal from State Completery-premately or other place)	State
Page al direc		4 Doneston O Other (Specify) HOITY HIII Mem. Gardens //10/1995 Baltimo	
ALTIN death. Pag hneral dis		Bruzdzinski Funeral Home P.A 1407 Eastern Ave.Balt., MD.	
		PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardlec or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate
filled in		IMMEDIATE CAUSE (Final)	Interval Between Onset and Death
within pleteh creman		Atherosclerotic cardiovascular disease Due TO (OR AS A CONSEQUENCE OF):	2weeks
68760 executed with and complet o burial, crer natic even	N	Sequentially list conditions, Due to construction of	
De e clan	ATIC	If any, leading to immediate cause. Enter UNDERLYING	
	CERTIFICATION	CAUSE (Disease or Injury that Initiated events resulting in death) LAST	
DS, P.O. the death certi			
m = 55 -	MEDICAL	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? ANALY OF THE PROPERTY PERFORMED?	RE AUTOPSY FINDINGS ILABLE PRIOR TO
AL RECOF he law requires that has been signed is Dept. of Health a	AED!	1 ☐ YES 2X NO OF	APLETION OF CAUSE DEATH?
law red as beer Dept. of			1120 2 110
	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 15/21 YES 2 NO 1 Inpatient 2 X ER/Outpatient 3 DOA 4 Muster Marie No. 1 DOA 4 Muster Marie No	
OF VIT, HYSICIAN: Th his certificate with the State ked, or item	3HX	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Rasidence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK?	
ON OI DING PHYS After this death with	ВУ	1 Netural 5 Pending 2 Accident Investigation M 1 YES 2 NO	
TISI TTEN TTEN after 28 is	COMPLETED	3 Suicide 6 Could not be detarmined 26a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 26b. LOCATION (Street and Number or Rural Route City or Town, State)	Number,
4 4 2 =	MPLE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.	
HOSPITAL FUNERAL WITHIN 72 P		MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and	
TO THE HOSPITA TO THE FUNERA De filed within 7	TO BE	delivary MP D27315	Day, Year)
16+1		Dr. M L Frydenborg 9000 Franklin Square Dr. Baltimore, Maryland 21237	- 4
.06		31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	
		111 1 1 1995 July dawdear Rawlet	



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DIVISION OF VITAL RECORDS, P.O. B

0 BALTIMORE, MARYLAND 21215-0020	ithin 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1. 2. 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	nt, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fune be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	ALICE	PLASO	CHKES	2	-	JULY 5	th 1993	
	4. SOCIAL SECURITY NUMBER 101-30-4090	1 M 2 X F	In yrs. last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) MAY 27,1	A BIS	THPLACE (State or Foreign AUSTRIA
NO.	80. FACILITY NAME (II not institution, give NORTHWEST HOSPIT				RANDALLST		9c. COUNTY OF	TIMORE
١٤	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT	PV.					I DITE.	
DIRECTOR	MARYLAND	BALTIMORE	106. 6114,	BALTII				10d. INSIDE CITY LIMITS? 1 YES 2 X NO
FUNERAL	100. STREET AND NUMBER 133 SLADE AVE.			101	ZIP CODE 212	00		F WHAT COUNTRY?
S	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC		C ORIGIN? (Specify Ver	US or No.— 14. R4	
BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES		If yes, sp	ecify Cuban, Mexican, 2 XNO Specify:	Puerto Ricen, etc.)	81	ICE — American Indian, ack, White, etc. ec/ly: WHITE
밀	15. DECEDENT'S EDU (Specify only highest grad	JCATION e campleted)	16e. DECEDENT'S U	ork done during mo	ON st of working	16b, KIND OF BU	SINESS/INDUSTRY	
COMPLETED	Elementery/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT use	retired.)		DE	TIA TT	
OM	17. FATHER'S NAME (First, Middle, Last)		DADLIC	TONDI	18. MOTHER'S NAM	E (First, Middle, Maiden	I'AIL Surneme)	
ш	MAX	HORN			JOHANNA		UNKNOWN	
10 B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING A	ADDRESS (Street a	nd Number or Rural Ro	oute Number, City or Tow		
	MR. JOHN	PLASCHKES				OWINGS M		
	20s, METHOD OF DISPOSITION 1 Paurial 2 Cremation 3 Ren 4 Donation 5 Other (Specify)	noval from State cam	PLACE AND DATE OF etery, crematory or oth BNAI ISRA	er place)			CATION — CHY OF	
	21. SIGNATURE OF FUNERAL SERVICE LI		DIGIT TOTAL	22. NAME AN	ID ADDRESS OF FACI	LITY		, MD
	> Gay (May	Louis				& BROS.,] FOWN ROAD		77 17 0101
	23. PART I Enter the diseases, or	complications that ceused List only one cause on ea	the death. Do no	ot enter the mo	de of dying, such	as cerdiec or reap	iretory arrest,	Approximate
	IMMEDIATE CAUSE (Fine) disesse or condition resulting in death)	s. A NO KLC DUE TO (OR AS A		ERHA	LOPATI	H -/		Interval Between Onset and Death
	Tooling in double							3011 3
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):			,		730A-15
FIC	CAUSE (Disease or Injury that initiated events	C. DUE TO (DR AS A	CONSEQUENCE OF):		<u> </u>			
ERT	resulting in death) LAST	d						
AL C	PART il. Other significent condition	ns contributing to death br	ut not resulting in	the underlying	ceuse given in P	art I. 24s. WAS AN	AUTOPSY 2	4b. WERE AUTOPSY FINDINGS
MEDICA	O ENENT	ı A				PERFOR		AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
 ₩	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YES	□ NO □	UNCERTAIN	_		1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH					
YSI	1 🗆 YES 2 🖫 110	1 Topatient 2 ER/Outp	etlent 3 DOA 4		s 5 ☐ Residence 6	☐ Other (Specify)		
ву Рн	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. TIME INJU	RY WO	URY AT RK? 'ES 2 NO	28d, DEŞCRIBE HOW II	NJURY OCCURED	
	3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY building, atc. (Speci	At home, farm, str	eet, factory, office		26f. LOCATION (Street e City or Town, Stete)	and Number or Run	l Route Number,
COMPLETED		ICIAN: To the best of my knowle						
BE CC	29h SIGNATURE AND TITLE OF CERTIFIE	R			29c LICENSE NUMB	ED.	204 DATE SIGNS	ED (Month Day Van)
7	30. NAME AND ADDRESS OF PERSON WI	O COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, P	rine)	D 434	Oceands III	house	5th 1995
	1C.S.R.M FT. 31. DATE FILED (Month, Day, Year)			ab red ,	ENTY,	ACCI AND IL	, 2000	(1.0)
	31. DATE PILED (MONIN, Day, Year)	32. REGISTRAR'S SIGNA	43					
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	. OR ATENDING PHYSICIAN: The law requires that the death certificate be executed within exhours after death. Page 6 may be retained by the hospital or attending physicis	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-ti
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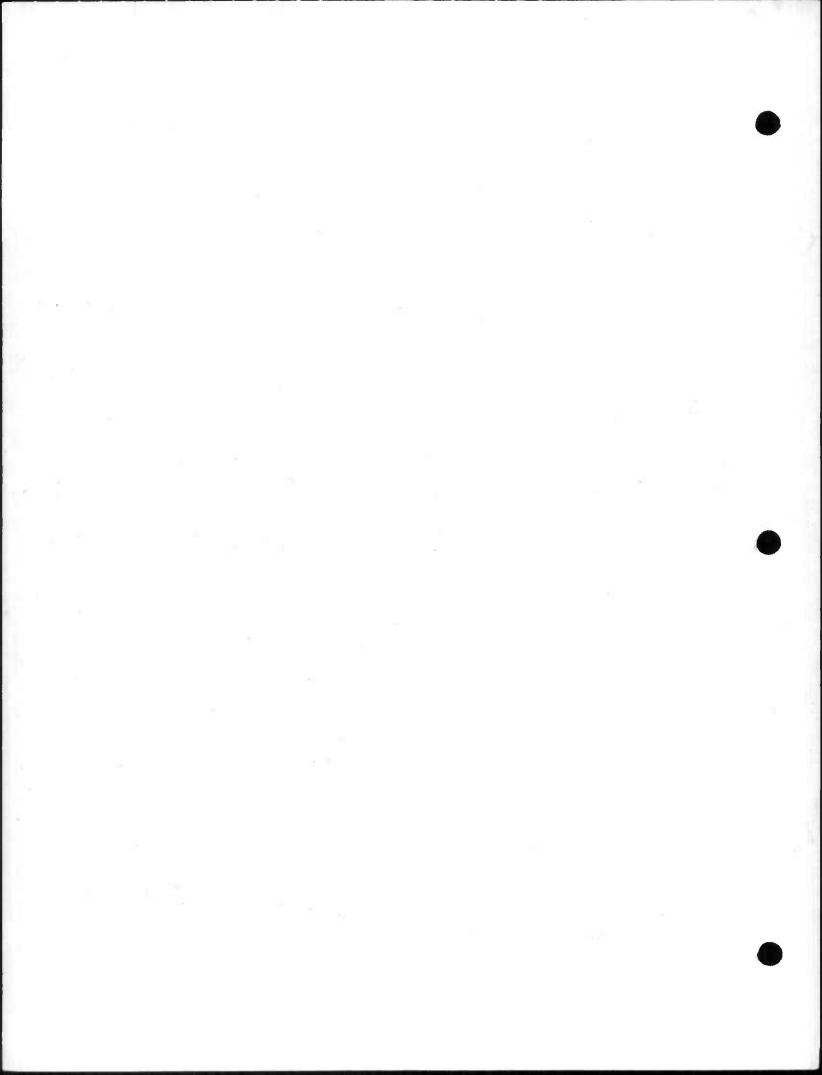
ling physician. the burial-transit permit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. — hours after death. Page 6 may be retained by the hospital THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last)	0				2. DATE OF DEATH		3. TIME OF DEATH
	GILMER H.	POLLARI		Jr.		JULY &	1 1995	2:55 PM
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIFT	THPLACE (State or Foreign
	212-50-2948	1 X M 2 □ F	47 YRS.	MONTHS DAYS	HOURS MIN.	Dec.8,19		lto. Md.
\ m	Sa. FACILITY NAME (If not institution, give s				OR LOCATION OF D	EATH	9c. COUNTY OF	
DIRECTOR	Northwest Hospi	tal Center		Kanda	11stown		Balti	more
Di Li	10a. STATE 10b. COUNT	Y	10c. CIT	Y, TOWN OR LOCA	TION			10d, INSIDE CITY
P	Md.	Baltimore		R	eisterst	own		LIMITS?
AL	100. STREET AND NUMBER			10	f. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?
FUNERAL	114 Main Str	et			2	1136		USA
J.	11. MARITAL STATUS 1 Never Merried 2 Married	12. WAS DECEDENT EVER II FORCES? 1 YES		13. WAS DEC	CENDENT OF HISPA	NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	or No- 14. RA	CE - American Indian, ck, White, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D			2 NO Speci			hite
	15. DECEDENT'S EDU	CATION	16a. DECEDENT'S	USUAL OCCUPATI	ON	16h, KIND OF BU	SINESS/INDUSTRY	inte
E	(Specify only highest grade	College (1-4 or 5+)	(Give kind of life, Do NOT u	work done during me se retired.)	ost of working		S	
JA I	High School		Maint	anceman		Apt.	Complex	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Middle, Maiden	Surname)	
BE		Pollard Sr.			Mar			
2	19a. INFORMANT'S NAME (Type/Print) Mrs. Pamela A. Po	Land				Route Number, City or Tow		
	20a. METHOD OF DISPOSITION			Main St		eisterstown		
	1 🗆 Buriel 2 🔯 Cremation 3 🗆 Rem	oval from State 20b	PLACE AND DATE	OF DISPOSITION (No	ame of	DATE 20c. LO	CATION — City or	Town, Stata
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	Callul	22 NAME A	ND ADDRESS OF FA	rice 7/10/9	Hamps	stead, Md.
	Kamsk	8/				11824	Reister	rstown Rd.
		xune		Eline	Funeral	Home Reist	erstown	Md. 21136
K	23. PART i. Enter the diseases, or shock, or heart failure.	complications that ceused List only one cause on a	i tha death, Do : ach lina.	not entar the mo	da of dying, aud	h as cardisc or resp	iratory arrest,	Approximate Interval Between
	IMMEDIATE CAUSE (Finel disease or condition	11-600-		0	~ 0=	-		Onset and Death
	resulting in desth)	DUE TO (OR AS A	CONSEQUENCE	- 21N	DILOME	>		
z								
유	Sequantially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE O	F):				
2	Cause. Enter UNDERLYING CAUSE (Disease or Injury	· ALCOHO	CONSEQUENCE O	USE				
E	that initiated eventa resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE O	F):	10	BLEEDI		
CERTIFICATION		d. Urrer 41	4591201	NIEST	INHL	176601	NG	
AL.	PART ii. Other aignificant condition	s contributing to death b	ut not reaulting	in tha undariyin	g cause given in	Part i. 24a. WAS AN		b. WERE AUTOPSY FINDINGS
	HNEMLA					1 YES 2		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME							/	1 TES 2 NO
z	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YE	S NO	UNCERTAI	NX		
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	TH (Check only one) OTHER:		7		
IYS	1 YES 2 NO	1 Appatient 2 ER/Outp		4 - Nursing Horr		8 Other (Specify)		
	1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b, TIM	URY WO	PRK?	28d. DEŞCRIBE HOW I	NJURY OCCURED	
BY	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF INJURY	- At home, term.		YES 2 NO	281. LOCATION (Street a	and Number or Burel	Pouts Number
윤	4 Homicide 6 Could not be	building, atc. (Spec	elfy)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, State)	ING NUMBER OF FIGURE	Noote Nomber,
3	29a. CERTIFIER 1 0 CERTIFYING PHYSI	CIAN: To the best of my know	lados dosth sosum	ad at the time date			2.7702.43	
COMPLETED		R: On the basis of examination						(a) and manner as stated
	296 ANATURE AND TITLE OF CERTIFIE				29c. LICENSE NUI			
BE	KALDOW Hower	PHYSICIAN			D 403		TI.	0 (Month, Day, Year)
2	30 NAME AND ADDRESS OF PERSON WH		ATH (ITEM 27) (Type	, Print)	9 103	2	JULY	7, 13
	PANKAT ROHT NEST	M. MOTOLO M	RHAR	5 Haco	GR. L	ANDALLE TO	IM ME	21/33
	31. DATE FILED (Month, Day, Year)	R REGISTRAN SIGN	ATURE	W. 17U 31-		JILUT-0 10	N'Y	FUSS
1	JIII 1 1 1995 %	AN DURING THE PARTY	and the same of th					1

BALTIMORE, MARYLAND 21215-0020	SICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	e medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL, OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 2	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fune be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, or remandon, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	*	1	

	1 - FOR STATE REGISTRAR	STATE OF MARYL			HEALTH AND		GIENE		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DE	ATH		3. TIME OF GEATH
	Alphonso Per	ry				July	DAY 7	95	10:40 a m
	4. SOCIAL SECURITY NUMBER	8. SEX 6. AGE ((In yrs. lest birthday)	IF UNDER 1 YEA			TH Mark		HPLACE (State or Foreign
	213-20-4313	NOM 2 □ F	70 YRS.	MONTHS DAY	B HOURS MIN.	(Month, Day, 12-6-		Count	"MD
	9e. FACILITY NAME (If not institution, give street	et end number)		96. CITY, TOV	N OR LOCATION OF	DEATH	9c, CO	UNTY OF E	
DIRECTOR	Sandtown Winche	Sandtown Winchester Nursing Hm Baltimore n/a							
RE	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LO	CATION				10d. INSIDE CITY
	MD n/	a		Ba1t	imore				1 NES 2 □ NO
FUNERAL	10g. STREET AND NUMBER			1000	101. ZIP CODE		10g. CI	TIZEN OF	WHAT COUNTRY?
Ä	2866 W. Garr				212				USA
5	11, MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 TYPES	U.S. ARMED	13. WAS	ECENDENT OF HISI specify Cuben, Mex	PANIC ORIOIN? (Spe lcan, Puerto Ricen,	city Yes or No-	14. RAC Blac	E — American Indien, k, White, etc.
BY	3 Widowed 4 Divorced	TI de La OIVE WAR OR DE	ATES 19 41		ES 2 00 Spe		,	Spec	Black
	15. DECEDENT'S EDUCA	TION	18a. DECEDENT'S	IISHAL OCCUR	TION	185 KINO	OF BUSINESS/IN	DUSTRY	DIACK
	(Specify only highest grade on Elementary/Secondary (0-12)			work done during		100. KINO	OF BUSINESS/IN	DUSTRY	
	unk.	College (1-4 or 5 +)	Bus D	river		Ba	1+imor	C C	ity School
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		- 0.0	22702	18. MOTHER'S	NAME (First, Middle.			rey benedi
	George S. Pe	rry				rce Per	,		
) BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Stre	et and Number or Rur			(Ip Code)	
임	Martha Leach				Garriso				D 21215
	200. METHOD OF DISPOSITION	20b	PLACE AND DATE	OF DISPOSITION			20c. LOCATION -		
	### Buriel 2 Cremetion 3 Remove 4 Donation 8 Other (Specify)	00111	etery, crematory or o		st Va	7/11	Owing	re M	ills, MD
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE		22. NAME	AND ADDRESS OF	FACILITY	_		
	Dames Ci	ma. 1	10)	Ja	nes A.	Morton	& Sons	Fu	neral Home
\neg	23. PART Enter the disesses, or cor	mplications that caused	the dasth. Do r	of enter the	01 Laur	ens St.	Balto) . /	MD 21217
	shock, or heert fellure. Lis	st only one cause on a	sch line.		. I	/	respiratory a	rest,	Interval Between
	IMMEDIATE CAUSE (Finsi disease or condition	Compag	tine !	legit	- Thi	ure			Onset and Death
	resulting in death) s.	DUE TO YOR AS A	CONSEQUENCE OF	19(1)	7911	-(1-			2 0045
_	-	Horself	nsion	,					UR
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	F): (1)		1.			1/13
8	Cause, Enter UNDERLYING CAUSE (Disease or Injury	The	Staa	e K	Pra/	disa	se		455
E	that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	5:	/				1,
EH	reaulting in death) LAST	Alcol	he	De	benda.	nae			413.
AL C	PART II. Other significant conditions	contributing to deeth b	ut not resulting	In the underl	ing cause given	n Part I 24a 3	MAS AN AUTOPSY	1 245	. WERE AUTOPSY FINDINGS
8					mig cause given	"	ERFORMED?	240	AMAILABLE PRIOR TO COMPLETION OF CAUSE
						 ¹□	YES 2 NO		DF DEATH?
Σ	DID TOBACCO USE CONTRII	RUTE TO CAUSE O	E DE ATH VE	ON D 2	UNCERTA	IN CO			1 NES 2 NO
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF DEAT						
S		HOSPITAL:		OTHER:			,		
Ĭ	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIM		ome 5 Residenc		HOW INJURY OC	CUBED	
	1 Natural 5 Pending	(Month, Day, Yeer)		URY	WORK?	200. DESCRIBE	HOW INSOMY OC	CONED	
BY	2 Accident Investigation 3 Suicide & Could get be	280. PLACE OF INJURY	At home, farm, a			28t. LOCATION	(Street and Numbe	or Rural I	Pouts Number
	4 Homicide 8 Could not be determined	building, etc. (Spec	Hy)			City or Town	, Stete)		Turnous,
۳	29a. CERTIFIER	N: To the heat of my travel	edea death						
COMPLETED	(Check only one) 2 MEDICAL EXAMINER:	AN: To the best of my knowl On the beels of exemination							Name and the second second
	296. SIGNATURE AND TITLE OF CERTIFIER								
B	Anna to 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	am			29c. LICENSE N	UMBER	29d. DA	TE SIONED	(Month, Ray, Yber)
임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	TH (ITEM 97)	Deint)	1 2	フンン	0/1	+ 11	0 175
	Amatan MMa	reem 50	20	510 3	treet E	-Hol)	110)6	1/2	17
	31. DATE FILED (Month, Day You) July	- 3 REGISTRAR GIGN	TUDE						
	10F T T 1329 Jun	1000	(=)						1



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ISICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physical content of the company of the property of the company of the property of the company of the	nd completely filled in by burial, cremation, or rem
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HOSPITAL OR ATTENDING	F FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transif r within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.
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Pages 1, 2, 3 should

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Albert A. Ritchie 1550 PM 7. DATE OF BIRTH (Month, Day, Year) 1995 4. SOCIAL SECURITY NUMBER S. BIRTHPLACE (State or Foreign Country) 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 219 01 9233 DAYS HOURS MIN. 1X M 2 F 79 YRS. Sept 915 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Anne Arundel Med Ctr. DIRECTOR Annapolis Anne Arundel RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY IGC. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md Anne Arundel Annapolis 1 X YES 2 NO FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21401 115 Silopanna Road USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or Noif yes, specify Cuban, Mexican, Puerto Rican, etc.)
 I YES 2 X NO Specify: 14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Merried ВУ Specify: 3 Widowed 4 Divorced 1942 1945 White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 166. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5 +) Govt. 12th Employee Relations 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Robert Ritchie notified at Elizabeth L. Garrison BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Marcia Moreland 3682 6th AVe., Edgewater, Md 21037 9 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Sista DATE must 1 To Burial 2 Cremation 3 Removel from State
4 Donation 5 Other (Specify) Cem Annapolis Md examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEI 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home P.A., Momeo 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cardiec or respiratory errest, Annapolis, Md medical **Approximata** shock, or heart fallure. List only one cause on each line. Interval Between **IMMEDIATE CAUSE (Final Onset and Death** the disease or condition Acute Myocardial Infarct event, resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING other CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS **AMILABLE PRIOR TO** any COMPLETION OF CAUSE Anemia 1 - YES 2 NO Shows 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO E UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Item HOSPITAL:
1 □ Inpetient 2 ♥ ER/Oulpetient 3 □ DOA OTHER: 1 - YES 2 NO 4 - Nursing Home 5 - Residence 8 - Other (Specify) 0 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) marked, 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1X Natural 1 YES 2 NO BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, Ierm, street, lectory, office building, etc. (Specify) 3 Suicide 28I. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide determined 29e. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(s) end manner ea stated. TO THE HOSPITAL OF THE FUNERAL DE FILED WITHIN 72 his IMPORTANT; If IL (Check only one) MEDICAL EXAMINEIS On the be is of axamination end/or investigation, in my opinion, death occured at the lime, date end place, end due to the ceuse(e) end menner as stated. AND TITLE OF CERTIFY 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

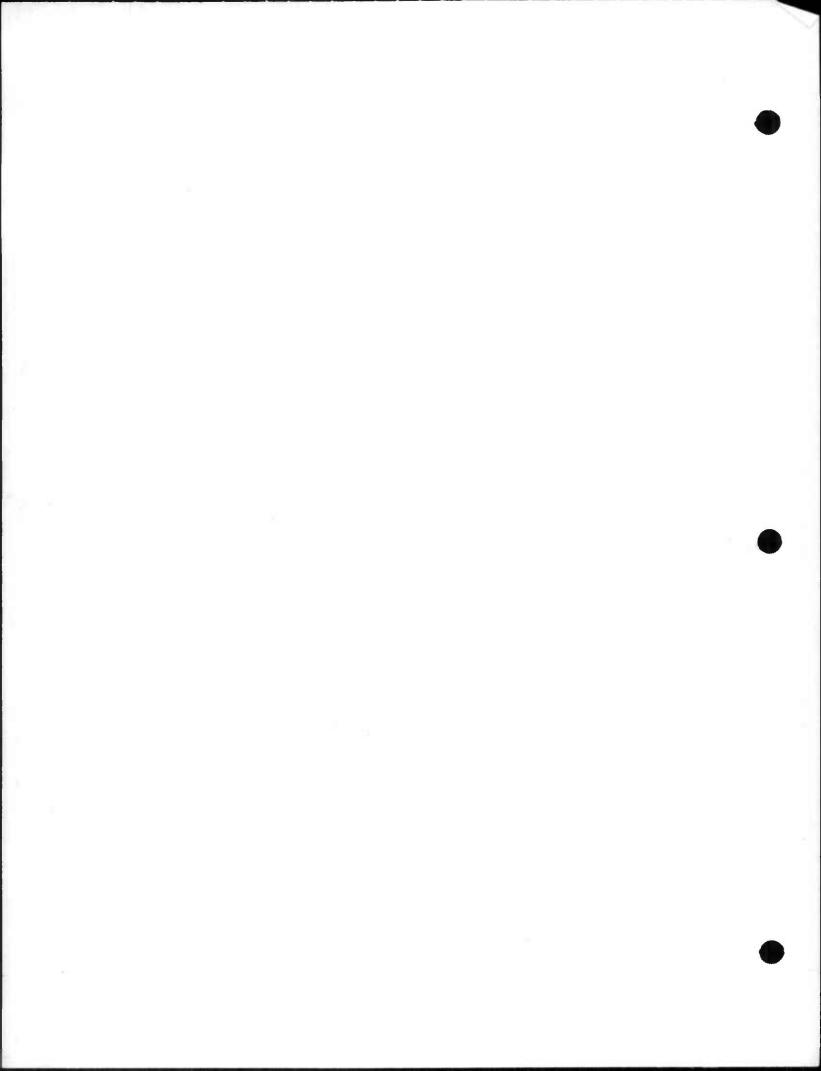
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PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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July 1995

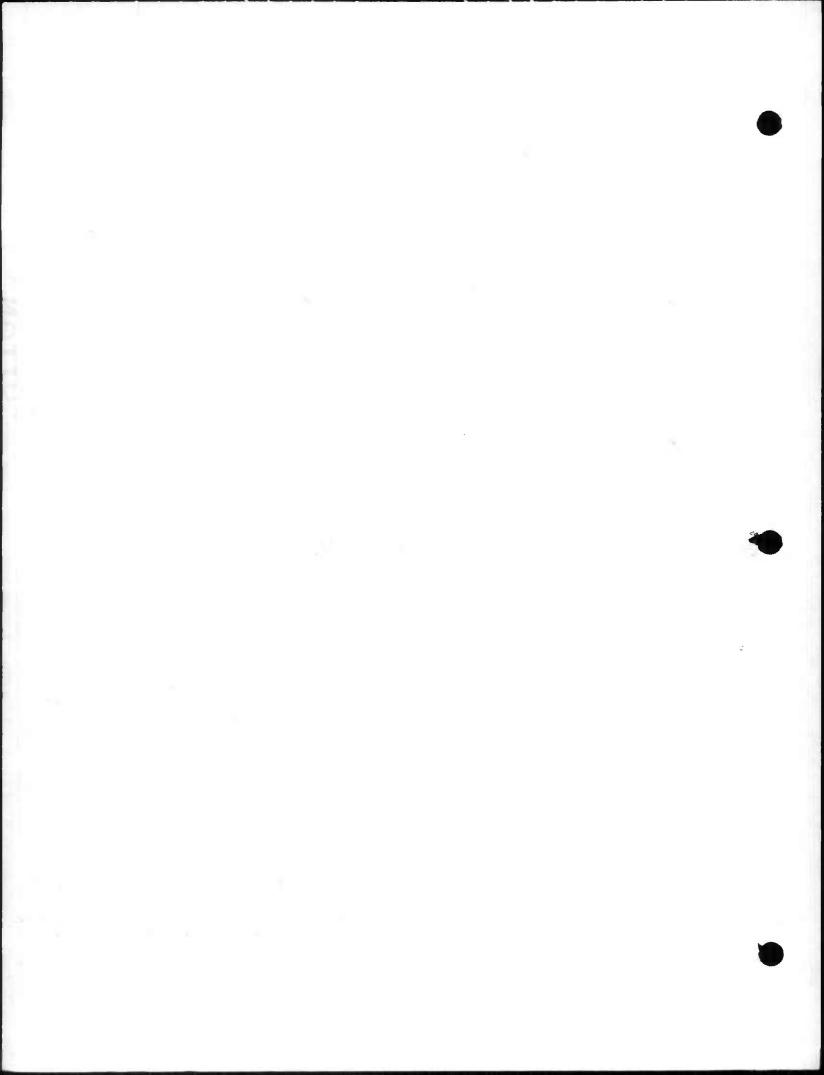
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DALINOUL,	s after death. Pay	by the funeral d
	HOU	filled in
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed witking hours after death. Page 6 may b	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page
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_	FOR 1 - STATE REGISTRAR	STATE OF MARY		MENT OF HEALTH AND CATE OF DEATH	MENTAL HYGIEN REG. NO		
	1. DECEDENT'S NAME (First, Middle, La	Μ.		DING	JULY -	7 199	5 0500
	4. SOCIAL SECURITY NUMBER 217-07-5395	1 3 M 2 □ F		IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year) 11-17-1	0	HRTHPLACE (State or Foreign Country) MARYLAND
ECTOR	99. FACILITY NAME (If not institution, git UNIVERSITY H RESIDENCE OF DECEDENT	OSPITAL		BALTIMORE	DEATH	9c. COUNTY	OF DEATH
DIREC	10e. STATE 10b. COU MARYLAND			TOWN OR LOCATION LTIMORE			10d. INSIDE CITY LIMITS? 1 X YES 2 NO
FUNERAL	100. STREET AND NUMBER 701 EAST 33R	D STREET	•	101. ZIP CODE 21218			OF WHAT COUNTRY?
BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EYER FORCES? 1 YES IF YES, GIVE WAR OR WWII	S 2 NO	13. WAS DECENDENT OF HISP/ It yes, specify Cuban, Mexic 1 YES 2 NO Specific Specif	en, Puerto Ricen, atc.)		RACE — American Indian, Black, White, etc. Specify: WHITE
LETED	15. DECEDENT'S E (Specify only highest gr Elementary/Secondary (0-12)	College (1-4 or 5+)	Iffe. Do NOT use	rk done during most of working retired.)	16b. KIND OF BU		RY
COMPLET	17. FATHER'S NAME (First, Middle, Last) JOHN M. REDD	2YRS.	ALCOHOL	All your agents of	AME (First, Middle, Maiden	OF MD) .
TO BE	190. INFORMANT'S NAME (Type/Print) EILEEN M. RE			DDRESS (Street and Number or Rure EAST 33RD ST			
	20e. METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 R 4 Donation 5 Other (Specify)		Db. PLACE AND DATE OF	DISPOSITION (Name of	DATE 20c. LO	LTO., M	or Town, State
	21. SIONATURE OF FUNERAL SERVICE	LICENSEE R. Pares I		22. NAME AND ADDRESS OF F HENRY W. J 4905 YORK	ENKINS &	SONS	co.
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS DUE TO (OR AS	A CONSEQUENCE OF:	L HEMORE	HAGE		
MEDICAL C	PART II. Other significant condit	iona contributing to death	but not resulting in	the underlying cause given in	Part I. 24s. WAS AN PERFOR	RMED?	24b. WERE AUTOPSY FINDS AMALABLE PRIOR TO COMPLETION OF CAU OF DEATH?
SICIAN: P	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH	(Check only one)	IN Z		
РНУ	1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending	1 Inpetient 2 ER/Ou 28e. DATE OF INJURY (Month, Day, Year)	tpatient 3 DOA 4	RY WORK?	8 Other (Specify) 28d. DESCRIBE HOW I	NJURY OCCURE	D
тер ву	2 Accident Investigation 3 Suicide 8 Could not determined	28s. PLACE OF INJUR	RY — At home, farm, str		28t. LOCATION (Street City or Town, Stete)	and Number or Ru	ural Route Number,
COMPLE				at the time, data and place, end du in my opinion, death occured at th			ise(e) and manner se state
TO BE C	296. SIGNATURE AND TITLE OF CERTIF	Benny Ell	DEATH (ITEM 27) (Type, P		766	≥ Jul	NED (Month, Day, Year)
	JOSEPH G. 31. DATE FILED (MONTH, Day, Year) JUL 1 1 1995	BUSSEL THE	UNIVE	ERSITY OF M	ARYLAND ALTIMORE	22 MD	South Gre 21207

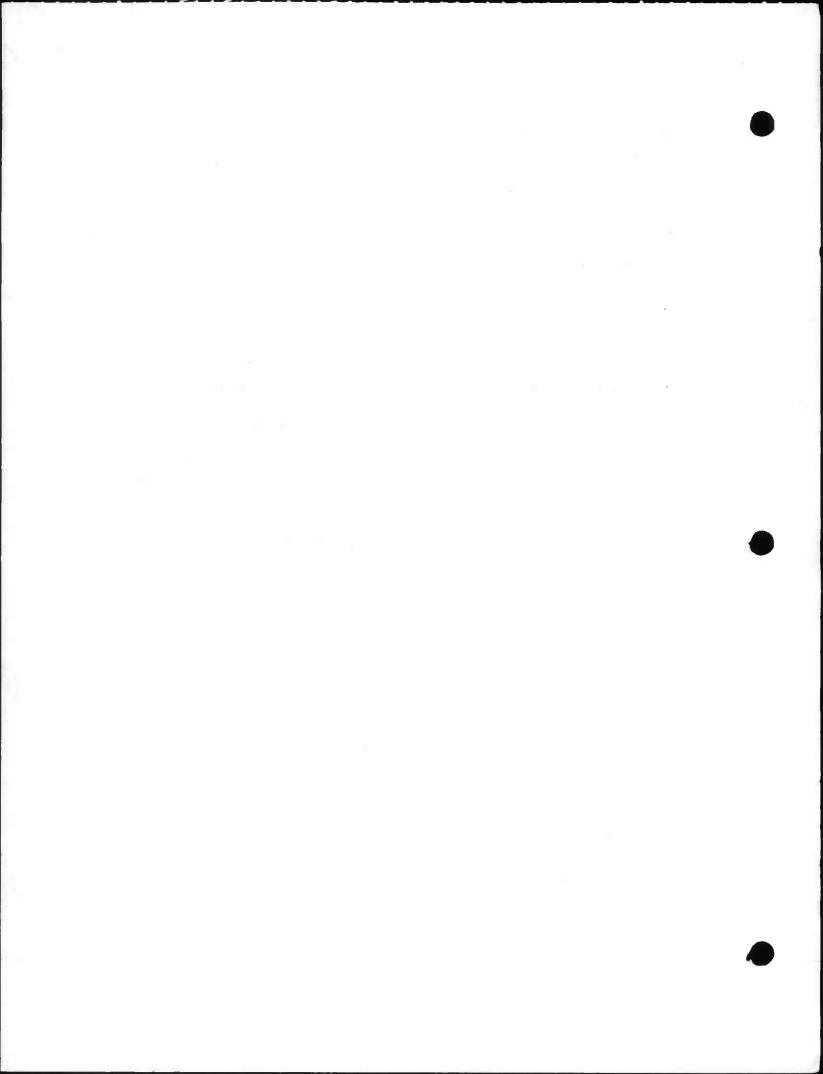


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BOX 6876
RDS, P.O.

BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	he medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR		CERTIF	-ICATE (OF DEATH	REG.	NO.	
1	1. DECEDENT'S NAME (First, Middle, Last) J. Bernard	Raffe	rty			2. DATE OF DEAT	N DAY	YEAR 3. TIME OF DEATH
3	4. SOCIAL SECURITY NUMBER	5. SEX 6. A	MGE (In yrs. last birthday)			7. DATE OF BIRTI (Month, Day, Ye.		6. BIRTNPLACE (State or Foreign
	212-09-1468	1 🔀 M 2 🗆 F	89 YRS.	MONTHS DA	YS HOURS MIN.	May 20,	1906	Country) Md
~	9a. FACILITY NAME (If not institution, give st			9b. CITY, TO	WN OR LOCATION OF D			INTY OF DEATN
FUNERAL DIRECTOR	Charlestown Care	Center		Cat	onsville		Ba	ltimore
EC.	10a. STATE 10b. COUNTY		10c. CI	TY, TOWN OR L	CATION			10d. INSIDE CITY
ā	Md Bal	timore	(Catonsv	ille			1 XYES 2 NO
₹	10e. STREET AND NUMBER				10f. ZIP CODE		10g. CIT	TZEN OF WHAT COUNTRY?
ÿ	715 Maiden Choice				21228			USA
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EV FORCES? 1 1	rES 2 NO		DECENDENT OF NISPAI L. specify Cuban, Maxico			14. RACE — American Indian, Black, Whita, atc.
B	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE WAR O	OR DATES	10	YES 2 NO Specif	y:		Specify: White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade		18a. DECEDENT'	Work done durin	PATION g most of working	16b. KIND OI	BUSINESS/IN	
91	Elementary/Secondary (0-12)	College (1-4 or 5+)	IIIe. Do NOT	use retired.)				
MP	12 17. FATNER'S NAME (First, Middle, Lest)	4	Steam S	hippin	g Executiv		Marit	ime
ö		Eerty			Kathy	ME (First, Middle, Ma	niden Surname)	
BE	19a. INFORMANT'S NAME (Type/Print)		19b, MAILIN	G AODRESS (Str	eet and Number or Rural		Town State 7	n Code)
2	Reverend Brian Rai	fferty			Road, Pa			
	20a. METHOO OF DISPOSITION 1 X Burlat 2 Cremation 3 Ramo	over from State	20b. PLACE AND DATE	OF DISPOSITIO				City or Town, State
	4 Donation 5 Other (Specify)		New Cath	edral (Cemetery	7/11 B	altimo	re. Md.
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSPE	٨		erling Ash		ral Ho	ne
	Ketter &	welled.	Meol	730	Edmondso	n Avenue	. Balt	o. Md. 21228
	23. PART I. Enter the diseases, or cahock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cause of the con	on aach lina.	nal	Far 1 /4 /		espiratory ar	rest, Approximata Interval Between Onast and Daath
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	λ.,	AS A CONSEQUENCE O					
	PART II. Other significant conditions	contributing to daa	th but not reaulting	in the under	ying cause given in		S AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
EDICAL							S 2 NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEI							^	1 TYES 2 NO
ä	DID TOBACCO USE CONTR	RIBUTE TO CAUSI				N 🗆		
SC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF OE	OTHER:				
PHYSICIAN:	1 YES 2 NO 27. MANNER OF DEATN	1 Inpatient 2 ER/	RY 28b. TII		Nome 5 Residence	6 Other (Specify) 26d, DESCRIBE H	OW IN ILIES OC	CURED
ВУ Р	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Ye	ar) IN	JURY M 1	WORK?		ow moon oc	
COMPLETED	3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJ building, stc. (URY — At home, term, Specify)	atreet, tectory,	offica	28t, LOCATION (St City or Town, S	reet and Numbe itate)	r or Rural Route Number,
2 1	29a. CERTIFIER (Check only	DIAN: To the beat of my k	nowledge, death occur	red at the time,	Sate and place, end due	to the cause(a) and	manner aa sta	ted.
∑	one) 2 MEDICAL EXAMINE	3: On the basis of examin	ation and/or investigati	on, in my opinio	n, death occured at the	time, data and plac	e, and due to ti	he cause(a) and manner as stated.
B	29b. SIGNATURE AND TITLE OF CERTIFIER	~ In n			29c. LICENSE NUM			E SIGNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	DOMPLETEO CAUSE OF	OEATH (ITEM 27) (Type	o, Print)	1/370	. ~	1,0	Lage 21228
	31 DATE FILED (Mouth Day Vant	106699	4 MD	701	Maria	ca (he	ilee 6	-646 CIECA
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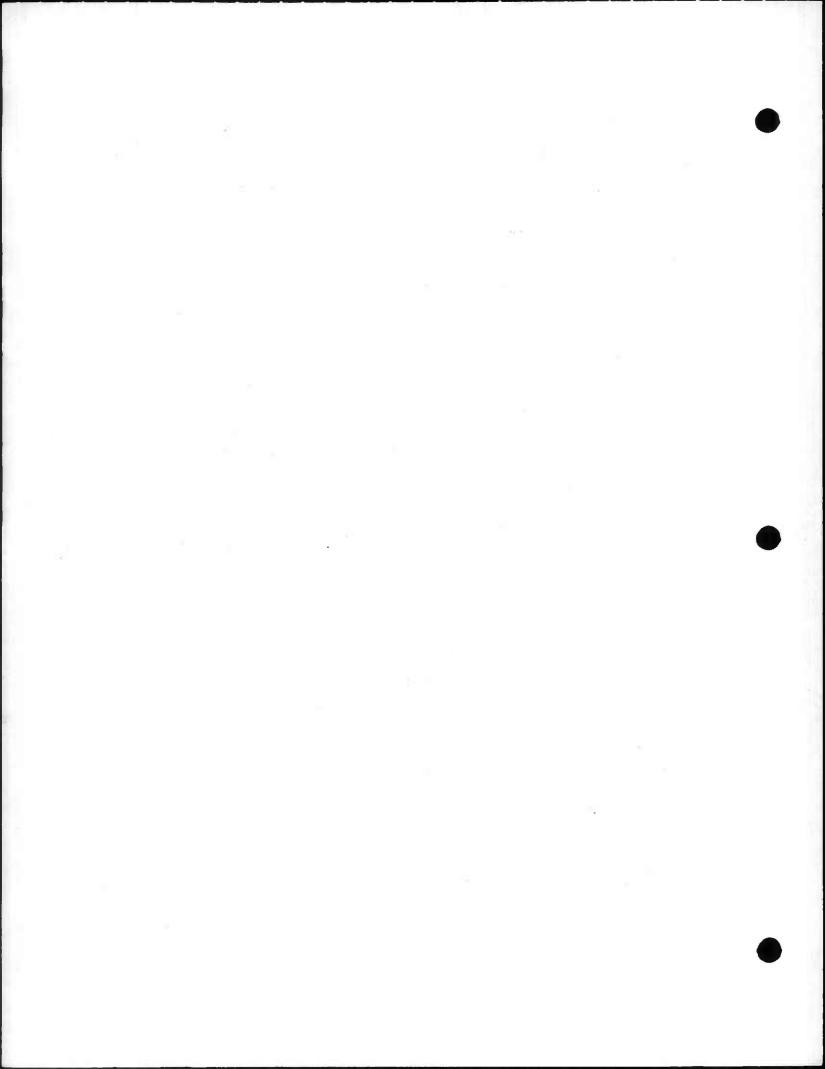
DIVISION OF VITAL RECORDS, P.O. BOX 68769

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. In hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC			MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Lest) DOROTHY		ROBINSON			2. DATE OF DEATH MONTH JULY 6,		3. TIME OF DEATH 3 PM M
	4. SOCIAL SECURITY NUMBER 148-24-5739	. □ M 2 G S		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Morth, Day, Year) DEC. 18,1		BIRTHPLACE (State or Foreign Country) NEW JERSEY
TOR	90. FACILITY NAME (If not institution, give CHERRYWOOD MANOR RESIDENCE OF DECEDENT				EISTERST		9c. COUNTY BALT	
DIRECTOR	10a. STATE 10b. COUNT NEW JERSEY	ESSEX	10c. CITY, T	WEST (10d. INSIDE CITY LIMITS? 1 XYES 2 NO
FUNERAL	100. STREET AND NUMBER 115 OLD SHORT HI	TTC DOAD ADD	7 201		ZIP CODE	2		OF WHAT COUNTRY?
BY FUNE	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES	U.S. ARMED	If yes, sp	ENDENT OF NISPA	NIC ORIGIN? (Specify Yes	or No 14.	RACE — American Indian, Black, White, atc. Specify: WHITE
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)	UCATION le completed) College (1-4 or 5+)	16a. DECEDENT'S USI (Give kind of work life. Do NOT use re	done during mo tired.)	st of working	16b. KIND OF BUS	I SINESS/INDUST	RY
OMP	12 17. FATHER'S NAME (First, Middle, Last)		Н	OUSEWI		ME (First, Middle, Meiden		
BEC	JACOB	STERN	J			LEN	ourner	ROSENBAUM
2	190. INFORMANT'S NAME (Type/Print) MRS. HELANA YO	NOWITZ				POUTE Number, City or Town		
	20 METHOD OF DISPOSITION	20h	PLACE AND DATE OF D				CATION - City	
	1 🕒 Burlel 2 🗆 Cremation 3 🗆 Ren 4 🗆 Donation, 5 🗀 Other (Specify)	01/1	HAR SINAI			10-1995 OW	INGS M	ILLS, MD
	21. SIGNATURIS CONFUNERAL SERVICE U	Bugar	/	SOL 1	REISTER	& BROS.,	BALTIN	MORE, MD 21215
	23. PART I. Enter the diseases, of shock, or hasrt fellure.	complications that caused List only one cause on a	the deeth. Do not ach line.	enter the mo	de of dying, suc	h as cerdisc or respi	ratory srreet,	Approximete Interval Between
	iMMEDIATE CAUSE (Fine) disease or condition resulting in death)	DUE TO (OR AS A	ta Static	Adem	Case insta	of Rect	om	Onset and Death
ATION	Sequentially list conditione, if any, leading to immediate cause, Enter UNDERLYING	b DUE TO (OR AS A	CONSEQUENCE OF):			V		
ERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	d.	CONSEQUENCE OF):					
SICAL C	PART II. Other significent condition	ns contributing to deeth b	ut not regulting in t	he underlying	ceuse given in	Part i. 24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC								OF DEATH? 1 YES 2 NO
PHYSICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL		F DEATH YES 26. PLACE OF DEATH (-	UNCERTAIL	N 🗆 📗		
25	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outp	0	THER:	5 🗆 Residence	6 Other (Specify)		
	27. MANNEY OF DEATH 1 Natural 5 Pending	20e. DATE OF INJURY (Month, Day, Yeer)	28b. TIME OF	WO	RK?	26d. DESCRIBE NOW IN	JURY OCCURE	:D
D BY	2 Accident investigation 3 Suicide e Could not be	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, stree		ES 2 NO	26f. LOCATION (Street e City or Town, State)	nd Number or R	ural Route Number,
EIED	4 Homicide determined			-				
COMPLE	(Check only 1 CERTIFYING PNYS	SICIAN: To the best of my knowl EFI: On the basis of examination						use(e) end manner ee stated.
מנו	296. SIGNATURE AND TITLE OF CERTIFIE	A O			29c. LICENSE NUI	ABER (29d. DATE SIG	GNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WE	HO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Prin	71)	リンチ	034	1/1/5	7,1995
	Try Hunter Cope 31. DATE FILED (Morith, Day, Year)		5310 Old	Court	Roal Su. 1	e 201 Runda	Ustaw	W 21133
	JUL 1 1 1995	Tallia Marches Ro	clath					



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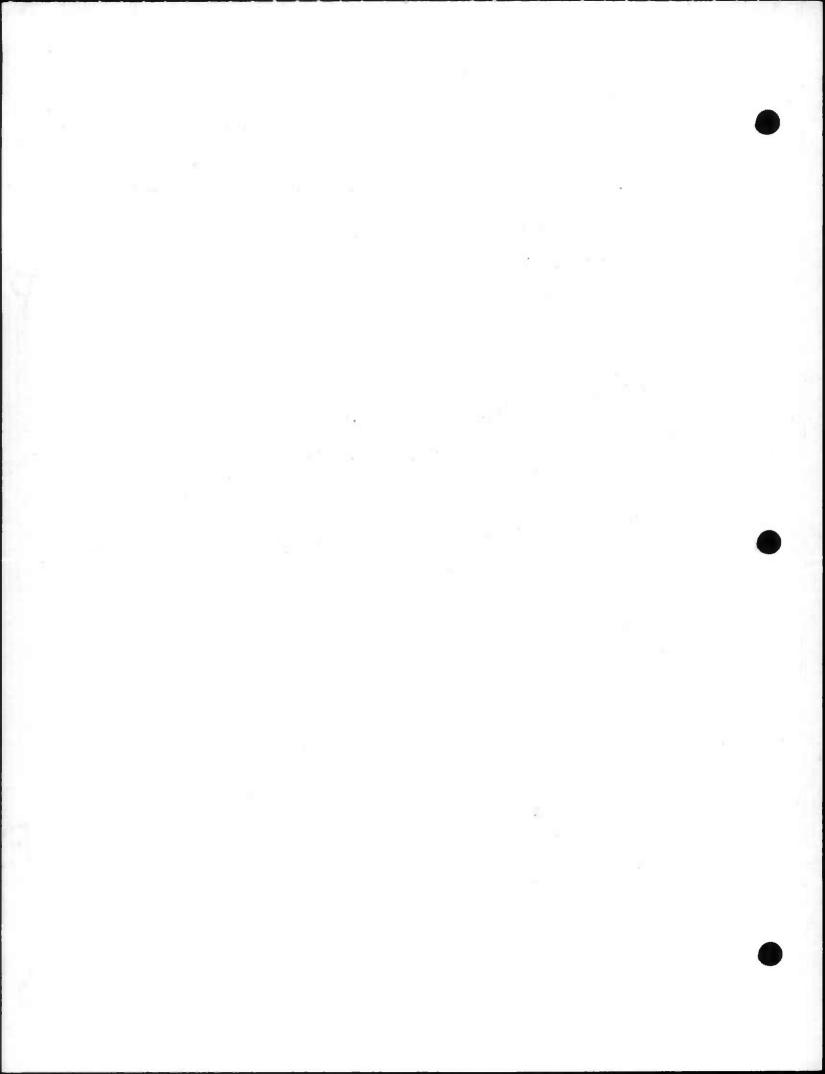
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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after de	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical ex
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FOR STATE REGISTRAR 10a STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO

1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATN 3. TIME OF DEATH ESTELLE RUBIN JULY 6, 1995 1:40AM 4. SOCIAL SECURITY NUMBER 6. AGE (In vrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year, B. BIRTNPLACE (State or Foreign IF UNDER 1 YEAR | IF UNDER 24 HRS 219-18-1110 1 M 2 F 70 DAYS HOURS JULY 22,1924 MARYLAND 9e. FACILITY NAME (If not institution, give etreet and number 9h. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR 812 WOODGLEN PLACE BALTIMORE BALTIMORE RESIDENCE OF DECEDENT 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY BALTIMORE BALTIMORE 1 YES 2 NO MARYLAND FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 21208 USA 812 WOODGLEN PLACE 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 14. RACE — American Indian, Black, White, etc. Never Married 2 Merried If yes, specify Cuber
1 ☐ YES 2 🕅 NO FORCES? 1 TES 2
IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced Specify: Specify. WHITE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during most of working life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) OWN HOME HOUSEWIFE 12 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA SOLIN BE **ABRAHAM** KATZ 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rurel Route Number, City or Town, State, Zip Code, ဥ 11229 WELLAND ST. N POTOMAC, MD 20878 RUBIN MARC 20a METHOD OF DISPOSITION
1 Buriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State 4 ☐ Donation 6 ☐ Other (Specify) BOBROISKER BENEFICIAL CIRCLE 7-7-1995 - ROSEDALE, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 272 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 the diseases, or complications that coused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Betw IMMEDIATE CAUSE (Fine) Onset and Death disease or condition 13 Month resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other aignificent conditione contributing to deeth but not reaulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 1 YES 2 NO OF DEATH? 1 TYES 2 T NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO PHYSICIAN: UNCERTAIN 25. WAS CASE REFERISED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpetient 3 | DOA 4 ☐ Nursing Home 5 PResidence 6 ☐ Other (Specify) 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT 26d. DESCRIBE NOW INJURY OCCURED 1 W Natural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — Af home, farm, street, fectory, office building, stc. (Specify) Sulcide 6 Cauld not be 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 2 MEDICAL EXAMINER: On th nination end/or investigation, in my opinion, death occured at the fime, date end place, end due to the cause(e) end menner as stated. TITLESOF CERTIFIER for Dr Marshall 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Levine JULY 6, 1995 2 COMPLETED CAUSE OF DEATH (ITEM 27) / Type, Pring 4000 REGISTRAR'S MONATURE Mudsor Narlatt



BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tran	
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95 20888 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH JULU 1995 HYMAN ROTHMAN 8:29 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (MONTH), Day, Year), 1910 IF UNDER t YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Formion DAYS NEW YORK 1 M 2 F 84 YRS. 215-07-2735 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH RECTOR SINAI HOSPITAL BALTIMORE N/A RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 X YES 2 NO ō MARYLAND N/A BALTIMORE 10s. STREET AND NUMBER FUNERAL 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2713-B JEREMY COURT 21209 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Noif yes, specify Cuban, Maxican, Puerto Rican, etc.)
 T YES 2 X NO Specify: 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 1 Never Married 2 Married 2 NO Specify: BY 3 Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY ntery/Secondary (0-12) College (1-4 or 5+) MAILER BALTIMORE SUNPAPER 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) EVA STERN BE **ROTHMAN** ISRAFI 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS /Str MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zin Code) 2713—B JEREMY COURT BALTIMORE, MD 21209 2 **ROTHMAN** MR. BARRY 20e. METHOD OF DISPOSITION
1 Å Burlal 2 ☐ Cremation 3 ☐ Remoral from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE 4 Donalion 5 Other (Specify) BETH YEHUDA ANSHE KURLAND -9-1995 BALTIMORE, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MD 2121 SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, 23. PART I. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximata ehock, or heart failure. Liet only one ceuse on sech line. interval Between **IMMEDIATE CAUSE (Final Onset and Death** disease or condition LAUTIC ACIDOSIS resulting in death) DUE TO (OR AS A CONSEQUENCE OF URINARY TRACT CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

					1 YES 2 W NO
DID TOBACCO USE CONT	RIBUTE TO CAUSE OF DEA	TH YES	NO D UNCERTA	IN 🔲	
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		CE OF DEATH (Check	only one)		
1 YES 2 NO	HOSPITAL: 1 M Inpetient 2 ER/Outpetient 3	OTHE	R: rsing Nome 5 - Rasidence	6 Other (Specify)	
27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DEŞCRIBE NOW INJURY OCCUR	ED
3 Suicide 8 Could not be	26e. PLACE OF INJURY — At he building, etc. (Specify)	ome, farm, street, lac	tory, office	281. LOCATION (Street and Number or I	Rural Route Number,

29a. CERTIFIER ERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) end manner as stated. MEDICAL EXAMINER: On the mination and/or investigation, in my opinion, death occured at the time, data end place, end due to the cause(s) and manner as stated.

29b. SIGNATURE A TITLE OF CERTIFIER 29¢ LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) MEDICAL REGIDENT D47462

. NAME AND ADDRESS OF	F PERSON WHO	COMPLETED C	NUSE OF DEATH (ITEM 27) (Ty	pe, Print)
JEFFREY	BASA,	MP	SINAI	HOSPITAL

determined

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SINAI 32. BEGINTRAITS SIGNADRE 1995

6,

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO

OF DEATH?

July

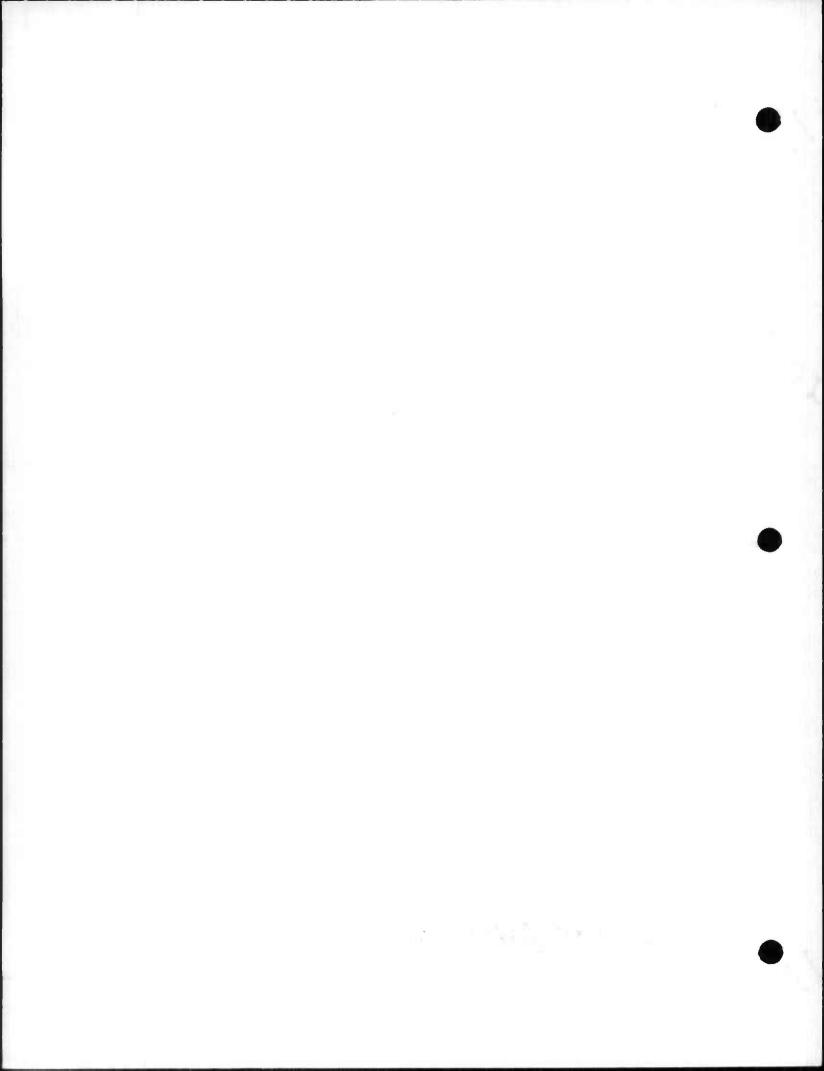
COMPLETION OF CAUSE

24a. WAS AN AUTOPSY PERFORMED?

1 YES 2 NO

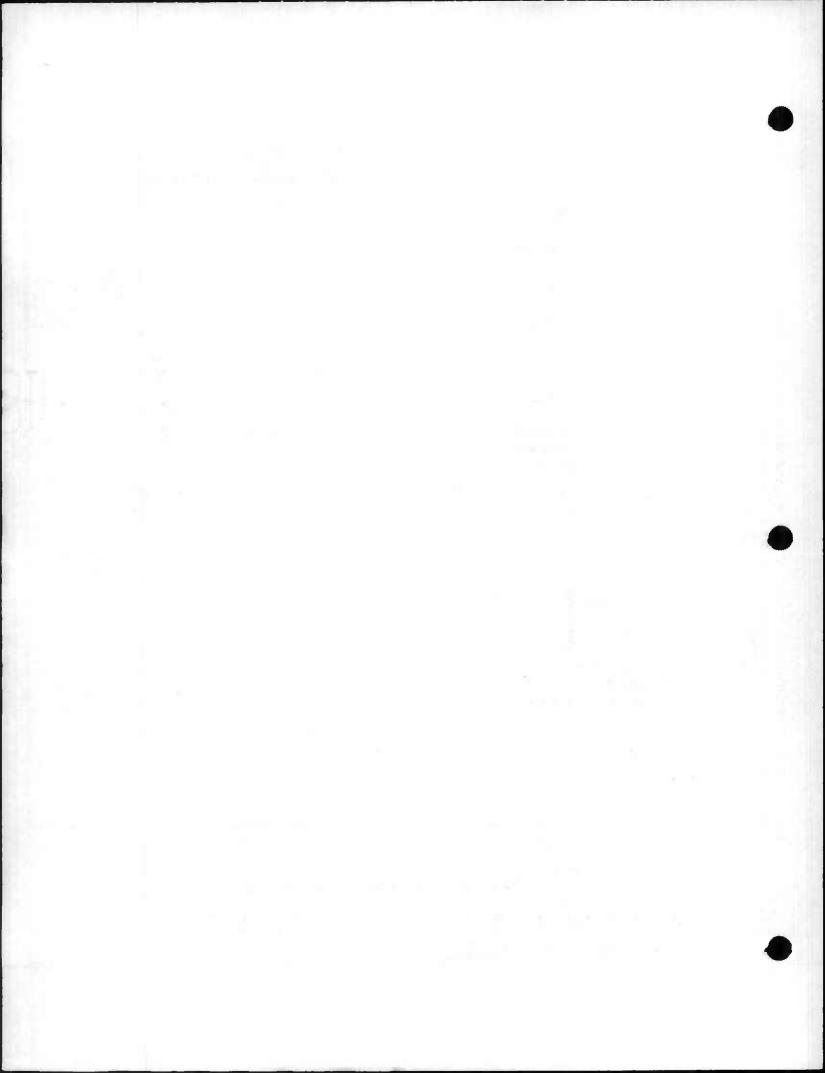
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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death, Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hypiene prior to burial, cremation, or removal.	SANATANITY IS formed on the months of the sanataning of the sanata
THE HOSPITAL OR ATTE	THE FUNERAL DIRECTOR OF filed within 72 hours after	SABORTANTE, 16 IA DO

	500							3	3 20009
	1 - STATE REGISTRAR	STATE OF N	IARYLAND / DE	PARTMENT	OF HEALTH AN	D MENTA	REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, Las	()	OLII	TITIOATE	OI BEAITI		E OF DEATH		3. TIME OF DEATH
	Dr.Herman Roge	ers				Ju	Ty 19	199	2:30 A
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birt	hday) IF UNDER		/4.4	OF BIRTH		BIRTHPLACE (State or Foreign Country)
	321-38-1265	1 🔀 M 2 🗀 F	90	'RS.	DAYS HOURS MIN		e 30, 19	905	Pennsylvania
-	9a. FACILITY NAME (If not institution, give	street and number)		9b. CITY,	TOWN OR LOCATION OF	F DEATH		9c. COUNT	Y OF DEATH
Ę	Fairhaven				Sykesvil	le			Carroll
DIRECTOR	10a. STATE 10b. COUN	ITY	10	c. CITY, TOWN O	LOCATION				10d, INSIDE CITY
	Maryland Car	rroll Cour	ity		Sykesville	e			LIMITS?
FUNERAL	10e. STREET AND NUMBER				101. ZIP CODE			10g. CITIZE	N OF WHAT COUNTRY?
Ë	7200 Third Ave	enue			2178	4		U.	S.A.
E	11. MARITAL STATUS 1 Never Married 2 Married		T EVER IN U.S. ARMED	1	AS DECENDENT OF HIS yes, specify Cuban, Me	PANIC ORIGI	N? (Specify Yes Rican, etc.)	or No-	4. RACE — American Indian, Black, White, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE W			TYES 2 X NO Sp		, , ,		Specify: White
8	15. DECEDENT'S EC	DUCATION	16a. DECEDI	ENT'S USUAL OC	CUPATION	16/	b. KIND OF BUS	INESS/INDUS	
<u> </u>	(Specify only highest gra-	College (1-4 or 5 +) Iffe. Do I	VOT use retired.)	uring most of working				
MP		8		Medical	Doctor		Не	alth	Care
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				Settle Section		Middle, Maiden S		
ш		S. Rogers					fleta		
TO B	19a. INFORMANT'S NAME (Type/Print) Mrs. Helen M. H	Pogors			(Street and Number or Ru				
3			20b. PLACE AND		rd Avenue				
	20a METHOD OF DISPOSITION 1 A Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	cemetery, cremator			7/14/			y or Town, State
	21. SIGNATURE OF FUNERAL SERVICE L	JCENSEE /	Joanian		AME AND ADDRESS OF		93 wa	rren,	PA
	· Grian a	e Thia	(st	H	AIGHT FUNI	ERAL H	OME (P	.O. B	ox 195)
	23. PART I. Enter the diseases, pr	//	caused the death	Do not enter t	Sykesville	MD MD	21784	(410)	-795-1400
	shock, or heart fellure IMMEDIATE CAUSE (Fine)	. List only one caus	se on aach line.		no mode or dying, a	IOCII MM CMI	orac or reapir	atory arrea	interval Between
	disease or condition	meto	static	pros	tate 1	an c	e.r		Onset and Death
	reaulting in death)	DUE TO	OR AS A CONSEQUEN	CE OF):	tate c	. CAT C			many
Z	Sequentielly list conditions,	ь							7200
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO	OR AS A CONSEQUEN	CE OF):					
JE C	CAUSE (Disease or Injury	c. DUE TO	OR AS A CONSEQUEN	CE OEI:					
F	that initiated events resulting in death) LAST			0. 0. 1.					
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MEDICAL	PART II. Other aignificant condition			ting in the und	erlying couse given	in Part I.	24s. WAS AN A PERFORE		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ŏ	tract inc	eumoni	a and	UPIA	ary		1 TYES 2	NO NO	COMPLETION DF CAUSE OF DEATH?
	Tract Inc	CLTION	0						1 TYES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL				05 04 405 05 05 T				
SICI	EXAMINER? 1 YES 2 NO	HOSPITAL:	ER/Outpatient 3 🗆 D	OTHER					
Н	27. MANNER OF DEATH	28a. DATE OF	INJURY 286	TIME OF	ng Home 5 - Resident		SCRIBE HOW IN	JURY OCCUR	RED
ВУ Р	1 Natural 5 Pending	(Month, Da	y, Ybar)	INJURY M	WORK? 1 YES 2 NO				
	2 Accident investigation 3 Suicide 8 Could not be	28e. PLACE OF	INJURY — At home, fi	arm, street, factor	y, offica	28f. LOC	ATION (Street ar	nd Number or	Rural Route Number,
	4 Homicide determined		10,000.00			City	or Town, State)		
PLE	29a. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the best of	my knowledge, death o	courred at the tin	e, data and piece, and o	due to the ce	use(s) and mann	ner as stated.	
COMPLETED									ause(s) and manner as stated.
BE C	29b, SIGNATURE AND TITLE OF CERTIFIC	ER 1	01		29c. LICENSE P	NUMBER		29d. DATE S	IGNED (Month, Day, Year)
TO B		Cir,	0: N	NMD	1344	106		17,	10/95
	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUS			1 51 .			4.1	
	31. DATE FILED (Month, Day, Year)	P. Al		645	Libert-	rka	, Eld	ا کس	ours, MD
	JIII 1 1 1005	32. REGISTRAF	S SIGNATURE						
	JULI 1333 X	and and and	Marie						



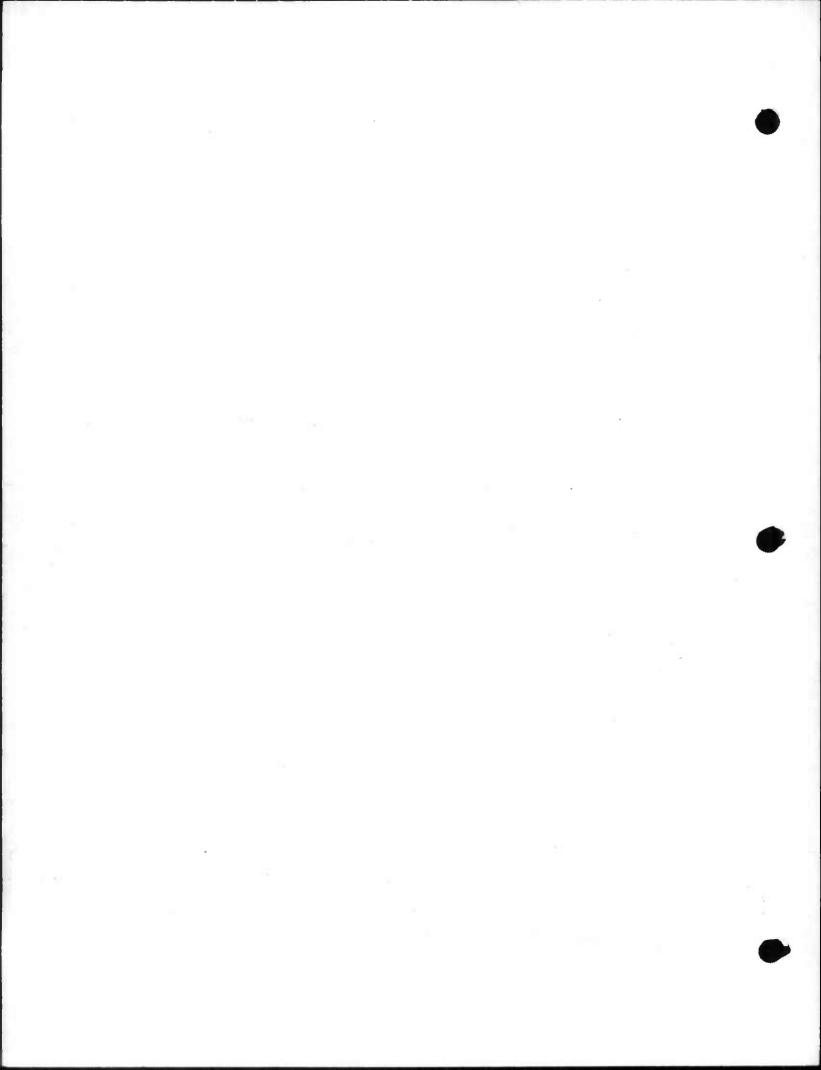
BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

permit. Pages 1, 2, 3 should funeral director, page 5 should be detached for use as the burial-transit the hospital or attending physician. Page 6 may be retained by hours after death. filled in by the 6 the attending physician and completely fille Mental Hygiene prior to bunial, cremation, signed by the been ft, of h has be Dept. c The law r h the State L OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate I hours after death with the State . this c

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 3. TIME OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN YEAR STANLE OREVA July 8. BIRTHPLACE (State or Family Country) 6. AGE (In yrs. lest birthday) 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year IF UNDER 24 HRS. HOURS 1 M 2 F 70 YRS. 214-38-5866 Nov 7, 1924 North Carolina Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Northwest Hospital Randallstown Baltimore 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland n/a Baltimore 1 TYES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 902 Burnt Ember Court 21208 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 1F YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Norried ВУ 1 TYES 2 X NO Specify Specify: 3 Widowed 4 Divorced Bl.ack COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade of Elementary/Secondary (0-12) College (1-4 or 5+) College 8 Teacher Baltimore County Schools 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) 16 James M. Koger BE Annie Lee Hargraves notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Milton Stanley 902 Burnt Court Baltimore, 21208 Maryland | be 20e. METHOD OF DISPOSITION

| Surial | 2 | Cremation | 3 | Ramoval from State Jůly 1 11 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Surtal 2 Cremation 3 L 4 Donation 8 Other (Specify) must cemetery, cremetory or other place)
MD Veteran Cemetery/Garrison Owings Mills, MD examiner 21. SIGNATURE OF PIMERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, MD 21216 medical 23. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximats interval Between Onset and Dasth IMMEDIATE CAUSE (Finsi the disesse or condition ESOPHAGUS WITH METASTASIS OF resulting in death) 1994 event, traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AVAILABLE PRIOR TO any COMPLETION OF CAUSE 1 YES 2 NO Shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) ltem! HOSPITAL: OTHER:
4 | Nursing Nome | 5 | Residence | 8 | Other (Specify) 1 YES 2 NO 1 Donationt 2 ER/Outpatient 3 DOA 0 27. MANNER OF DEATH 28e. DATE OF INJURY 28c. INJURY AT WORK?

1 YES 2 NO 28d. DESCRIBE NOW INJURY OCCURED 26b. TIME OF marked, 1 Natural h. Day, Year) NA BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, ferm, atreet, fectory, office building, etc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number City or Town, State) 99 6 Could not be COMPLETED 4 Homicide N.4 29e, CERTIFIER 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the filme, date end piece, end due to the cause(e) end menner ee stated. THE HOSPITAL (
THE FUNERAL D
filed within 72 h = 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, end due to the ceuse(a) end menner ea stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: 1 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED A SE OF DEATH (ITEM 27) (Type, Print) Nontowost, Hospita 00214NOD COUGNAN 31. DATE FILED (Month, Day, Year) 1995



Thom#19 b. G-film 725 per F.H 7/12/95 P.C

	1, DECEDENT'S NAME (First, Middle, L	LEVA K	577	HNLEY	1	1. DATE OF MONTH	DAY	1985	3. TIME OF DEATH
	4, BODIAL RECURITY NUMBER 214-38-5866	The state of the s	(In yes test birthday)	MONTHS DAYS	# UNDER J4 Hfds. HOUTE MM.	7. DATE OF (Month D NOV 7	віптн / м. тові) , 1924	NO.	atipLace (Siete or robliga upiny) rth_Caroline
TOR	On FACILITY NAME (If not institution, or Northwest Hospi Anglidence of Orgeneral		*		allstown	HTA	9 c.	ва.	Ltimore
DIRECTO	Maryland		10c. OITY	Baltim					10d. Maide City
ERAL	104. STREET AND NUMBER 902 Burnt Ember	Court		100	21208		109	USA	OF WHAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECTIDENT EVER	IN U.S. ARMED 2 X NO DATES	II yes, ap	ENDENT OF HISPAN ecity Cuben, Mexice 2 NO Specin	n, Puerto Ale		0	NOCE — American Indian, Hack, White, etc. (peoply: Bl.ack
LETED	15. Dr.CEDENT'S (Specify wily highest Elementery/Recondery (0-12)	College (1-4 or 5+)	150, DECEDENT'S (QU'vo kind of w file, Do NOT use	work done during mo	DN ost of working		IND OF BUBINES		Ν
COMPL	17. FATHER'S NAME (First, Militia, Los	College 8	Teach	her	III. MOTHEN'S NA				ty Schools
TO BE (Jankes M. Koder 190. INFORMANT'S NAME (TOPOTOM) Milton Stanley)	106, MAILING	ADDRESS (SIMPLE)	Annie I	Route Number		ets, Zip Code	21208
	20e, METHOD OF DISPOSITION (V) flurial 2 Li Cremation 3 Li e i Donation 5 Li Diller (Specify) 21. SIGNATURE G FIMERAL SERVI	Removel from Blete ce	ob.PLACEANDOATEO motory, crematory or oil D Veteran	or bisposition (Not place) Cemater	v/Garriso	July on H	Owin	nos M	1118, MD 1118, MD
	IMMEDIATE CAUSE (Final	llure. List only one cause on	each line,	Baj.ti	nore, MD	212: h se derdis	C or respirato	ery acrest,	Approximate Interval Between Onset and De
	shock, or hoart fall IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initialed events	DUE TO (OR AS	each line,	Ballti Ballti De Gu	nore, MD	212: h se derdis	C or respirato	ery acrest,	Approximate Interval Betw
DICAL CERTIFICATION	shock, or hoart fall immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS	A CONSEQUENCE OF	Ballti Ballti Ballti Ballti File File Ballti	S WITH	212 h se dardis	C or respirato	DPSY	Approximata Interval Betwonset and D Separation of Cause Authors Finding to Completion of Cause Authors Interval and Authors Interval and Interval a
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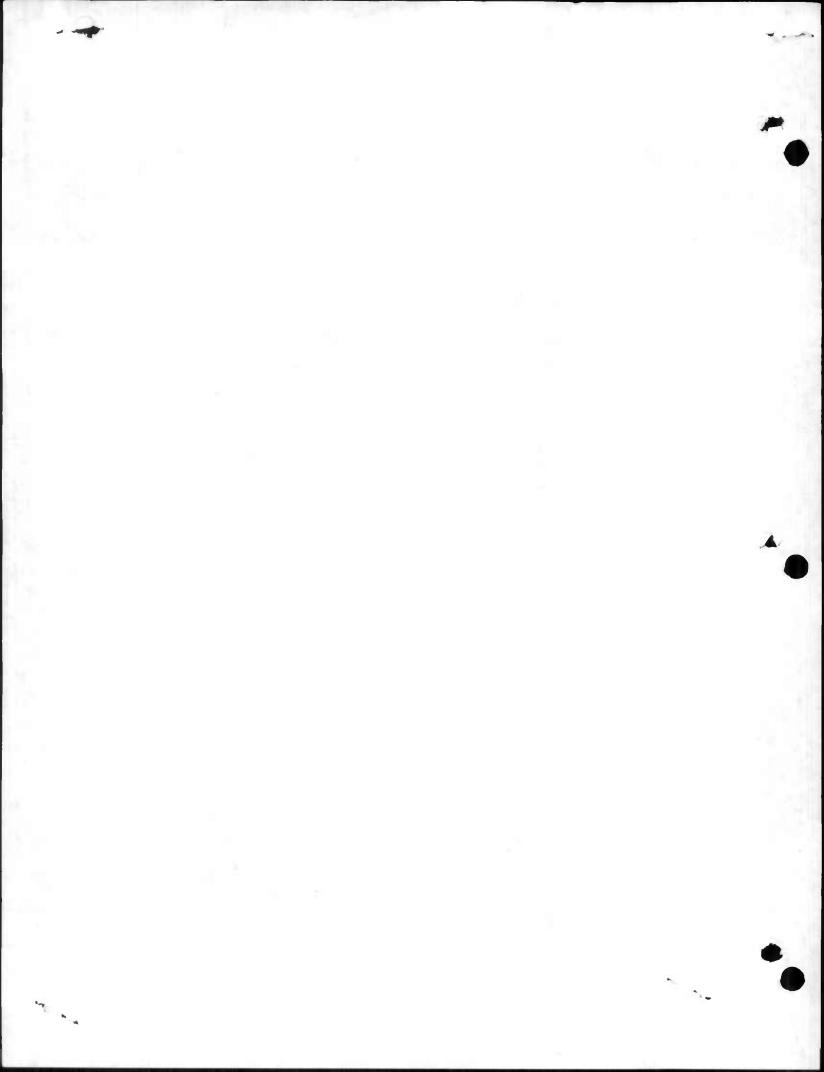
house after Ceats. Page 5 may be intained by the hospital or absorbing physicaln.

When the formal director, page 5 should be displaced for use as the build-basest cernif. Pages 1, 2, 3 should be described.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68764

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			1 - STATE REGISTRAR	STATE OF MARYL		RTMENT OF I		MENTAI	REG. NO.			
			1. DECEDENT'S NAME (First, Middle, Last)	Sally :	B. Smit	:h			of DEATH	95	EAR 3.	TIME OF DEATH
permit Pages 1.2.3 should			4. SOCIAL SECURITY NUMBER 219 – 38 – 8056		(In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE	OF BIRTH 1, Day, Year) -01-11	8.	BIRTHPL Country)	ACE (State or Foreign
	3 should	æ	a. FACILITY NAME (If not institution, give st 1016 Brantley	rect and number)		96. CITY, TOWN	or Location of the			9c. COUNTY		inia M
	1, 2,	СТОВ	RESIDENCE OF DECEDENT								7	
	nit. Pages	DIREC		/A	10c. CI	ry, town on local Balt	imore					INSIDE CITY LIMITS? TYPES 2 NO
		FUNERAL	10s. STREET AND NUMBER	_		10	f. ZIP CODE			10g. CITIZEI	OF WHA	AT COUNTRY?
yan.	burial-transit	NE I	1016 Brantley	Street 12. WAS DECEDENT EVER II	NII C ADMED		21217			U.		
215-0020 attending physician.	the burial	BY FU	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES	2 PNO	If yes, sp	CENDENT OF HISPA Secify Cuban, Maxic 3 2 5 NO Speci	an, Puerto F	? (Specify Yee o Rican, etc.)	r No 14	Black, V	American Indian, white, etc. Black
21215 or attend	2	ETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)		18e. DECEDENT'S (Give kind of life. Do NOT u	USUAL OCCUPATION Work done during moise retired.)	ON ost of working	18b.	KIND OF BUSIN	NESS/INDUS	TRY	
ND 2	8	COMPL	12th	0	Custo	dial			Govern	nment	:	
YLAN by the h	at de	ш	17. FATNER'S NAME (First, Middle, Last) Payton Davis		D-MAC-01		18. MOTNER'S N. Gert:	NAME (First, Middle, Meiden Surneme) crude Pullen				
MAR	5 should notified	10 B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street e	and Number or Rural	Route Numb	oer, City or Town,	State, Zip Co	de)	
∑ e Z	2	۴		penter	1808	N. App	leton S	Stree	et Bal	to.	MD	21217
ORE 6 may	must t		20e. METHOD OF DISPOSITION 1 Burlel 2 Cremetton 3 12 Remo	wal from State 20b	. PLACE AND DATE	OF DISPOSITION (Na	ame of	DATE	20c. LOCA	TION - CIN	or Town	State
P 30 K	direct mer m		4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE	Itha G	COVE CE	Metery ND ADDRESS OF FA	7/9!	1701	014,	va	•
BALTIMORE, MARYLAND 21215-0020 hours after death. Page 6 may be retained by the hospital or attending physic of in by the funeral director, page 5 should be detached for use as the burial	the funeral dir wal.		· Dorotta 21		SP #28	L E.L.	Philli _I	s F	/H Bal	to.,	MD	onroe St . 21217
	E - 0		23. PART i. Enter the diseases, or contained abook, or heart failure. L	implications that caused list only one cause on a	d the death. Do ech line.	not antar tha mo	oda of dying, suc	ch aa card	lac or reapire	tory arrest	,	Approximate interval Batween
47			IMMEDIATE CAUSE (Final disease or condition	C	1:00	1. 2 001	100	11 ~ 1				Onset and Death
With	ompletely fille 1, cremation, event, the	ł	reaulting in death)	DUE TO TOP AS A	CONSEQUENCE O	PI:	Lave	unc				
Secured executed		z		ASCV	0		U					
S S	ysician and o prior to buris traumatic	CATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury c									
certific	Hygiene Or other	RTIF	that initiated avents resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE O	F):					-	
S, e dea	y the attered Memtal	E	PART II. Other aignificant conditions	contributing to death b	ust not requiting	in the underhale	a anna alum la	Diet /				
that OH	th and	DICAL			at not resorting	m tha directying	y cause given in	Part I.	24a. WAS AN AL PERFORM 1 YES 2	ED?	AV.	ERE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH?
7 8	20 5	MED	DID TORACCO LICE CONTR	UDULTE TO CALICE O	- D- A- 14		7				1	YES 2 NO
₩.	De De	AN:	DID TOBACCO USE CONTR		28. PLACE OF DEA		UNCERTAI	ΝЦ				
VIIAL AN: The lav	certificate h the State , or item	SICI	EXAMINER?	HOSPITAL:		OTHER:	o 5 Masidence	8 [Other	(Snec(fv)			
HYSICI	this certif with the rked, or	PHY	27. MANNER OF DEATN	28a. DATE OF INJURY (Month, Day, Year)	28b. TIN	IE OF 28c. INJ			CRIBE HOW INJ	URY OCCUR	ED	
NG PF	After this death with	BY	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆	YES 2 NO					
ATTENDING PHYSICIAN: The	after de	ETED	3 Suicida 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, ferm,	atreet, tectory, office	•		ATION (Street end or Town, State)	f Number or i	Rurel Rout	Number,
IL OR A	L OIREC 2 hours f item	P.	29a. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my know	ledge, death occurr	ed at the time, date	and place, and due	to the cau	se(e) end manne	er ee atated.		
TIASO	thin 7	COMPL	one) 2 MEDICAL EXAMINER	t: On the basis of axamination	n end/or investigation	on, in my opinion, d	leath occured at the	tima, date	end pleca, and	due to the c	euse(e) en	d manner se stated.
O THE H	TO THE FUNERAL O De filed within 72 ha IMPORTANT: If IN	H	29b. SIGNATURE AND TITLE OF CERTIFIER	out			29c. LICENSE NU D262	MBER 56	1	Ped. DATE SI	GNED (M	95 (Mar)
	,	2	30. NAME AND ADDRESS OF PERSON WHO BICH DUONG	700 WA	ATN (ITEM 27) (Type 1814 LNG	Print)	NVO 1	SALT	mort	M	0 2	1230
	/	H-			-				V			

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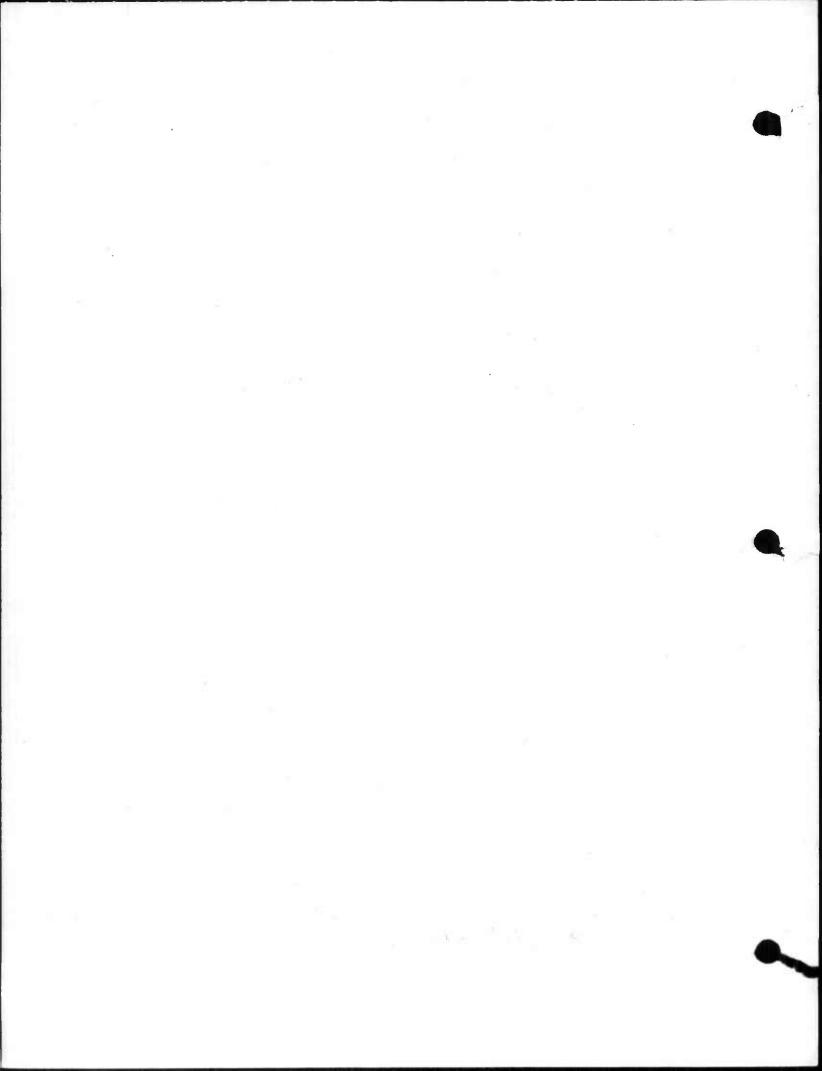
BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memai Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Hem 28 is marked, or Hem 23 shows any Inlury, or other traumatic event, the medical examiner must he marked at once.

_	1 - REGISTRAR CERTIFICATE OF DEATH REG. NO.									
		1. DECEDENT'S NAME (First, Middle, Last)	Keyshawn I				2. DATE OF DEATH	AY YEAR	3. TIME OF DEATH	
	- 1	KEYSHAWN _	WARR		00111616		JULY O			
1	- 1	4. SOCIAL SECURITY NUMBER		'In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		TTHPLACE (State or Foreign	
		215-90-0515		YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year)	978 100	untry)	
	1	9a. FACILITY NAME (If not institution, give st	(mei and number)	•	9h CITY TOW	N OR LOCATION OF DE	Dear 21,1	9c. COUNTY OF	anjano	
1 9	۲	UNIVERSITY HOS		Ţ		MORE CI		Se. COUNTY OF	A	
1 6	DIMECTOR	RESIDENCE OF DECEDENT			DALL	THORE CI	TI	1 2	177	
1 6	ᆲ	10a. STATE 10b. COUNTY		10c, CIT	Y, TOWN OR LO	CATION			10d. INSIDE CITY	
1 2	Ē	Manulara	SIA		. 1	MOYE			LIMITS?	
	- 1	100. STREET AND NUMBER	[] [1	1 PES 2 NO	
1	٤I	IN A P.	c. Cl . c.		i	101. ZIP COOE		10g. CITIZEN O	F WNAT COUNTRY?	
ELINEDAL	ă	1000	en street			0121	2	0.2	H	
1 6	2	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	13. WAS D	ECENDENT OF HISPA! specify Cyben, Mexice	NC ORIGIN? (Specify Yen, Puerto Rican, etc.)	86	ACE — American Indian, ack, White, etc.	
2	- 1	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	ATES		ES 2 NO Specifi		Sp	Black	
6		45. 050505030 -000	1							
H	-	15. DECEDENT'S EDUC (Specify only highest grade	completed)	18e. DECEDENT'S (Give kind of	work done during	TION most of working	16b. KIND OF BU	SINESS/INDUSTRY	,	
COMPI ET		Elementary/Secondery (0-12)	College (1-4 or 5+)	iile. Po NOT u	1		Hinh	who	rel	
3 3		11st grave		ONDO	ant		1119/1	wa		
5	3	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Surname)		
i a	ŭ	KOOSEVEIT DI	Thort			wand	A 4. B	anks		
		19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	t end Number or Rural I	Route Number, City or Tow		21205	
F	-	OHIRIEU IGBIA	ර	1401	Odes	ssa The	imas Ct	# 11 Ba	Himuse, Red	
		24. METHOD OF DISHOSITION	20b.	PLACE AND DATE	OF DISPOSITION			CATION — City or	Town, State	
		4 Donation 6 Other (Specify)	Will from State	etery, cremetory or o	NYE (emater "	7/7/9/180	1.toner	madelana	
		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE /	20-11-11-		AND ADDRESS OF FA	CILITY 2-5 (/A B	Partien	Trans of terms	
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	ł	23. PART I. Enter the diseases, or c	complications that caused List only one cause on a	the deeth. Do	not enter the r	node of dylng, suc	h es cerdiec or resp	Iratory arrest,	Approximete	
		IMMEDIATE CAUSE (Finel	List only one ceuse on ea	or line.	(1 A				Interval Between Onset and Death	
		disease or condition	(hat	· LA	Mou	- l	- North			
	N	resulting in death)	DUE TO (OR AS A	CONSEQUENCE O	FI:	00	1,00			
,	.								i	
CERTIFICATION	2	Sequentially list conditions,	DUE TO (OR AS A	CONSEQUENCE O	n:					
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I I	2 1	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE O	n:					
E		resulting in death) LAST			,					
	į		1							
		PART II. Other significent conditions	s contributing to death be	ut not resulting	in the underly	ng ceuse given in	Part I. 24s. WAS AN		4b. WERE AUTOPSY FINDINGS	
DICAL							PERFO		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
							YES 2	. □ NO	OF DEATH?	
2		DID TOP ACCOUNT	NIDITE TO CALICE O	F D F 1911 1/1		-		ļ	1 YES 2 - NO	
PHYSICIAN: MF		DID TOBACCO USE CONTR					1 🗆 📗			
2	5	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XES 2 NO		26. PLACE OF DEA	OTHER:	Θ)				
S	2		HOSPITAL:	etlent 3 🗆 DOA		ome 5 🗆 Reeldence	6 Other (Specify)			
H		27. MANNER OF DEATH	28e. DATE OF INJURY	26b. TIM		NJURY AT VORK?	28d. DESCRIBE HOW I	NJURY ACCURED	1 0	
λ		1 Natural 5 Pending 2 Accident Investigation	6/2419	5 72	The state of	YES 2 NO	Schi	ed 8	Loy	
		3 Suicide 6 Could not be	28e. PLACE OF INJURY	- At home, ferm,	treet, fectory, of	lice	281. LOCATION (Street	and Number or Rura	if Route Number,	
E		4 Homicide determined	building, etc. (Speci	""STOK	155		City or Town, Style)	(e. tro	1 Aug	
Щ		29e. CERTIFIER					1.611	, , ,	MANC	
COMPLETED		(Check only	CIAN: To the best of my knowle	edge, death occurr	ed at the time, da	te end place, end due	to the cause(e) end mer	ner as stated.		
Ö		ALKS MEDICAL EXAMINER	R: On the beele of examination	end/or investigation	n, in my opinion	death occured at the	time, date end place, en	d due to the ceuse	e(e) end menner ea stated.	
BE		290. SIGNATURE AND TITLE OF CERTIFIER	0 A1	1		29c. LICENSE NUM	IBER	29d. DATE SIGNI	ED (Month, Day, Year)	
		11/1/0-1	orle	M)		O.C.M.	E	▶,TIIT.V	2,1995	
2		10. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type,	Print)	1 5 5 5 5 1 1 1		0011	-11773	
		J. LARON LO	(KE,M) 1	11 Peni	Stre	et. Ralt	imore, M	arulan	d 21201	
	1	31. DATE FILED (Month, Day, Year)	32 REGITTRAITS SIGNA	WYRE	- DULC	ce, bart	THOLE, P	ату тап	u 21201	
		JUL 1 1 1995	Jahr Mariar	untall !					1	
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LTIMORE, MARYLAND 21215-0020 ttb. Page 6 may be retained by the hospital or attending physician. neral director name 5 should be discarbed for uses as the burnels have

DIVISION OF VITAL BECORDS

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	FOR STATE REGISTRAR	STATE OF MARYLA		ENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIEN	-		
	1. DECEDENT'S NAME (First, Middle, Last)	1 - 1	1.		2. DATE OF DEATH		3. TIME OF DEATH	
	Garald STICL	Air St	arlina			AY YEAR		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (II	n yrs. lest birth(ley) F	UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	1912	THPLACE (State or Foreign	
	212 - 22 - 222			THE DAYS HOURS MIN.	(Month, Day, Year)	Cou	intry)	
	0210 40 818		THS.		AUG.1.191	1 (1)	ARYLAND	
	9e. FACILITY NAME (If not institution, give :	street and number)	9b.	CITY, TOWN OR LOCATION OF I	DEATH	9c. COUNTY OF	DEATH	
DIRECTOR	FALLSTON GERS	RAL HOSPITA	12	FALLSTON		HARE	200	
5	RESIDENCE OF DECEDENT			T TASK TOTAL		THE	and	
1	10a. STATE 10b. COUNT		10c. CITY, TO	WN OR LOCATION			10d. INSIDE CITY LIMITS?	
₫	MARYLAND HAR	FORO	14	Sinboon			1 YES 2 NO	
7	10e. STREET AND NUMBER			101. ZIP CODE		10a. CITIZEN OF	WHAT COUNTRY?	
FUNERAL	2503 PRESTO	in LANE				1 2 5	Λ	
Z	11. MARITAL STATUS			21000		100.	14.	
	1 Never Married 2 Merried	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	13. WAS DECENDENT OF HISPA If yes, specify Cuben, Mexic	NIC ORIGIN? (Specify Yesen, Puerto Rican, atc.)	e or No- 14. RA Bis	CE American Indian, ick, White, atc.	
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA		1 TYES 2 NO Spec			ecity:	
						I U	3/1/40	
i iii	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16e. DECEDENT'S USU	AL OCCUPATION done during most of working	16b. KIND OF BU	SINESS/INDUSTRY		
[4]	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use reti	red.)				
COMPI	11 YRS-		EXPEDIT	SR	Basins	- Asport	Pars Compan	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			16. MOTHER'S N	AME (First, Middle, Maiden		THE ISSUED	
	Isonaen Enn	aktin Ster	10-1	0-	7 1	0	00000	
BE	190. INFORMANT'S NAME (Type/Print)	1111111 01516		1 11	H POUIT	HIL	SARALS	
유	O C - C () O-1		196. MAILING ADD	RESS (Street and Number or Rural		m, State, Zip Code)	, 21009	
'	LIHUCA T. LITO		19803 L	RESTON LANE	ABINGDO	al lar	YLAND	
	20e. METHOD OF DISPOSITION 124 Burlel 2 Cremetion 3 Rem	20b.	PLACE AND DATE OF DE	SPOSITION (Name of	OATE 20c. LO	CATION - City or	Town, State	
	4 Donation 6 Other (Specify)	Ceme	etery, crematory or other p	FATHLEM.	1,250 B	11017	Magyan	
	21. SIGNATURE OF FUNERAL SERVICE AN				ACILITY IS A COL	0.10	0 00	
	100	. /		22. NAME AND ADDRESS OF F	OT CHULT	- Deru	IN, MAKE	
		of Jones		3 NEWPORT (JH 715	W. MARYLAN	
	23. PART I. Enter the diseases, or	complications that caused	tha daath. Do not a	ntar tha moda of dying, su	ch as cardiac or resp	Iratory srrest,	Approximate	
		List Dnly pne cause on as	ch iina.				interval Batwee	
	iMMEDIATE CAUSE (Final disease or condition		2 -		۸ . ۱		Onset and Dear	
	resulting in death)	81.	Cull V	myocandu	a maja	ICHUS	15da	
		OUE TO (OR AS A	CONSEQUENCE OF):	J	2 . 0			
Z	Sequantially list conditions,		ngesti	ve heart	Lauler	10	15 der	
Ĕ	if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):		0			
2	cause. Entar UNDERLYING CAUSE (Disease or injury Cause (Disease or inju							
E	that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):					
CERTIFICATION	resulting in death) LAST	4.	mon's.	wochen	ic bear	t disc	are Syear	
					T SON	V 00.00	- Orjani	
AL	PART ii. Other significant condition	is contributing to death bu	it not resulting in th	a undarlying cause given in	Pert i. 24s. WAS AN		16. WERE AUTOPSY FINDING	
5					1 _ YES :	1	COMPLETION OF CAUSE	
MEDIC					' ' '	A.	OF DEATH?	
	DID TOBACCO USE CONT	DIDLITE TO CALICE OF	DEATH VEC I	T NO SZ UNICEDZU			1 TES 2 NO	
AN					и Ц			
호	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	6. PLACE OF DEATH (C	HER:				
S	1 TYES 2 NO	1 Inpatient 2 - ER/Outpa		Nursing Home 5 - Residence	6 Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	26b. TIME OF	28c. INJURY AT	28d. OESCRIBE HOW	NJURY OCCURED		
	1 Natural 5 Pending 2 Accident Investigation	(MONII, Day, Idei)	INJURY	M 1 YES 2 NO				
ВУ		280. PLACE OF INJURY	- At home, ferm, street		261. LOCATION (Street	and Number or D.	I Doute Number	
E	4 Homicide 6 Could not be	building, etc. (Specif	(y)	,y, with	City or Town, State)	HURE	THURST THURSDAY	
COMPLET	29e. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of my knowle	edge, death occurred at	the time, data end place, end du	e to the ceuse(s) end ma	nner es stated.		
S				my opinion, death occured at the			(s) end manner as stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIE							
BE	A A	1		29c. LICENSE NU	MBER	29d DATE SIGNE	D (Month, Day, Year)	
0	DWV4	100	MD	D 36	0115	7	8 195	
-	30. NAME AND ADORESS OF PERSON WH	O COMPLETED CAUSE OF DEA						
	DRSHERIF H.	OSMAN 50	17 Level 40	STRUET HE	ANDE GIL	O ZOAS	arus malva	
	31. DATE FILED (Month, Day, Year)	35. REGISTRAN'S SIGNA	тупе	31.00	WIN UCU	MILE 1 (1	IN ATIVE ONLY	
	JIII 1 1 1995	Julia Diwelson	Rawlalk					
	MULII NOU	All .						

Neutr sujocarded infaction 15day Congostive heart failure 150 Penal failure

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	1.	DE	CE	DEP	S'TV	NA
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	REGISTRAR		CERT	FICATE C	F DEATH		REG. NO.	_			
	1. DECEDENT'S NAME (First, Middle, List) 2. DATE OF GEATH 3. TIME OF GEA									TH	
	MILTON ALE		STUCK	JULY 06,1995			11:08	ΔΝ			
	4. SOCIAL SECURITY NUMBER 214-18-0056 5. SE		GE (In yrs. last birthda 78 YRS	MONTHS DA		7. DATE (Mont	OF BIRTH th, Day, Year)		8. BIRTH Countr	IPLACE (State or Fo	
E E	90. FACILITY NAME (If not institution, give atreet an GREENSPRING VALLE				VN OR LOCATION OF D		B. 18,	9c. COU	NTY OF D		
DIRECTOR	RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY	EI RD.	10e. (CITY, TOWN OR LO	SVILLE			BAL	TIM	ORE	
- 2	MARYLAND BALTIN	ORE				ALTI	MORE			LIMITS?	
FUNERAL	100. STREET AND NUMBER 3946 SETONHURST ROAD)			10f. ZIP CODE 21 208		10g. CITIZEN OF WHA			VHAT COUNTRY?	
	11. MARITAL STATUS 12. W	AS DECEDENT EVE	ES 2 NO	If yes	DECENDENT OF HISPA , specify Cuban, Mexico	in, Puerto	N? (Specify Yes Ricen, etc.)		14. RACE	E — American India c, White, etc.	en,
D BY	3 Wildowed 4 Divorced 15. DECEDENT'S EDUCATION	YES, GIVE WARFO	WII		YES 2 NO Specific				Speci	WHITE	
COMPLETED	(Specify only highest grade comple	ted) ege (1-4 or 5 +)	(Give kind	T'S USUAL OCCUP of work done during T use retired.)	ATION most of working	168	o. KINO OF BUS	BINESS/INC	USTRY		
OMP	17. FATHER'S NAME (First, Middle, Last)		ELEC	TRICAL	CONTRACTO		Middle, Malden		CTRI	CIAN	
BE C	MEYER		STUCK		LENA		Parent Belli	APTE			
2	19a. INFORMANT'S NAME (Type/Print) MRS GERTRIDE	STUCK			et and Number or Rural HURST ROAI		BALTTMC			1200	
	20a. METHOD OF DISPOSITION 15 Burlal 2 Cremetton 3 Removal fro 4 Donation 5 Other (Specify)		20b. PLACE AND OAT	TE OF DISPOSITION	/Name of	CAT	E 20c LO	CATION -	City or To	wa State	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE			22. NAM	NSHE SFARI	CILITY			SEDA	LE, MD	
	▶ allensue		noon	601	LEVINSON O REISTERS	NOTE	N ROAD	BALT	IMOR	E, MD 2	1215
	23. PART I. Enter the diseases, or complications that ceused the dasth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate interval Batween Onset and Death disease or condition resulting in death) II. MULTIPLE INJURIES										
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
EDICAL	PART II. Other significant conditions cont	g in the underl	n the underlying ceuse given in Part i.			Part I. 24a. WAS AN AUTOPSY PERFORMED?		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
N.	DID TOBACCO USE CONTRIBUT	E TO CAUSE	OF DEATH	YES NO	☐ UNCERTAI	N 🗆				1 YE\$ 2 N	10
PHYSICIAN:		PITAL:	26. PLACE OF OR	OTHER:		a W on		NI C			
Ě	27. MANNER OF GEATH 2	8a. OATE OF INJUR (Months Day, Yea 7/6/95			INJURY AT WORK?		SCRIBE HOW IN	JURY OCC	URED		_
à	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	JRY — At homa, tarm	TOUND 1 TYES 2 KNO			AUTO VS TRUCK COLLISION. 281. LOCATION (Street and Number or Rural Route Number, A.A.				15	
Ë	4 Homicide detarmined	building, etc. (Specify)								PIKESU	11/16
COMPLEIED	29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: TO MEDICAL EXAMINATE: On H									and manner as st	ated.
in in	266 SIGNATURE AND TITLE OF GENTRIER	6-10-00									
2	38 NAME AND ADDRESS OF PERSON WHO COMP	LETED CAUSE OF	BEATH (ITEM 27) (TH	pe, Print)	OCME			JU	JLY	07,199	5
I	Mario F. Golle Jr	M.D.	111 Per	nn Str	eet, Bal	timo	re, M	lary.	land	21201	
	A.	2. REGISTRAR'S SI	GNATURE								



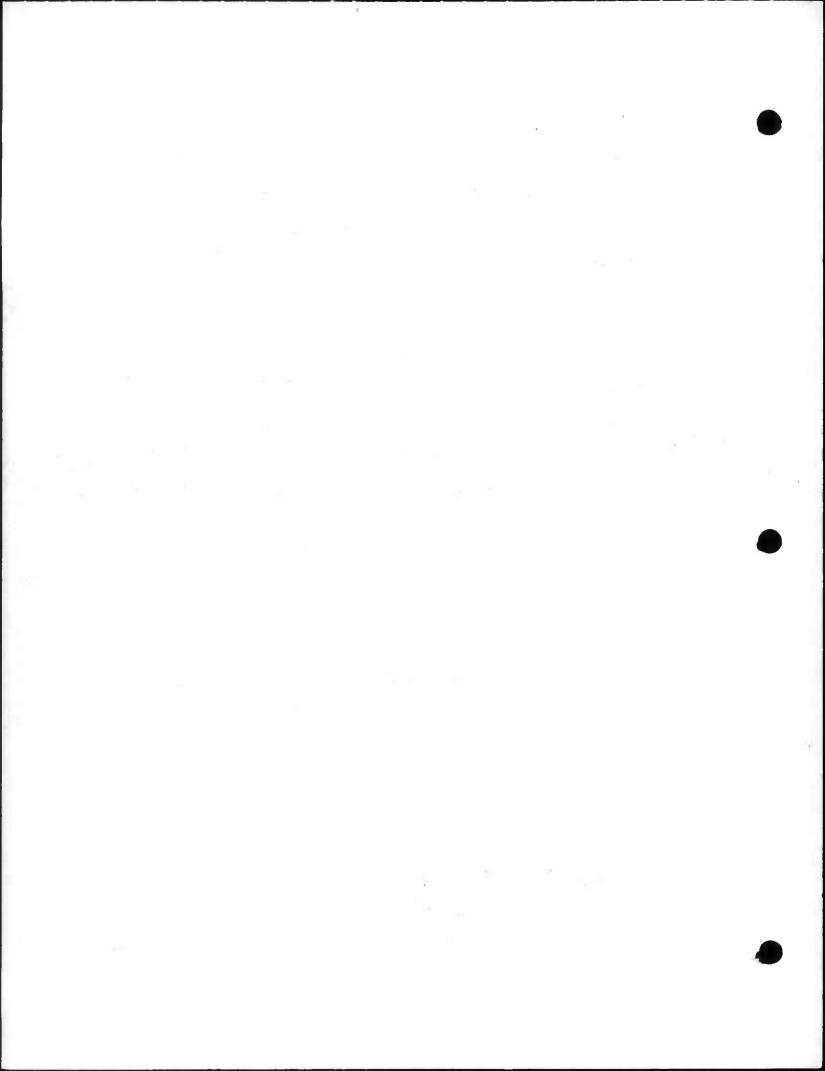
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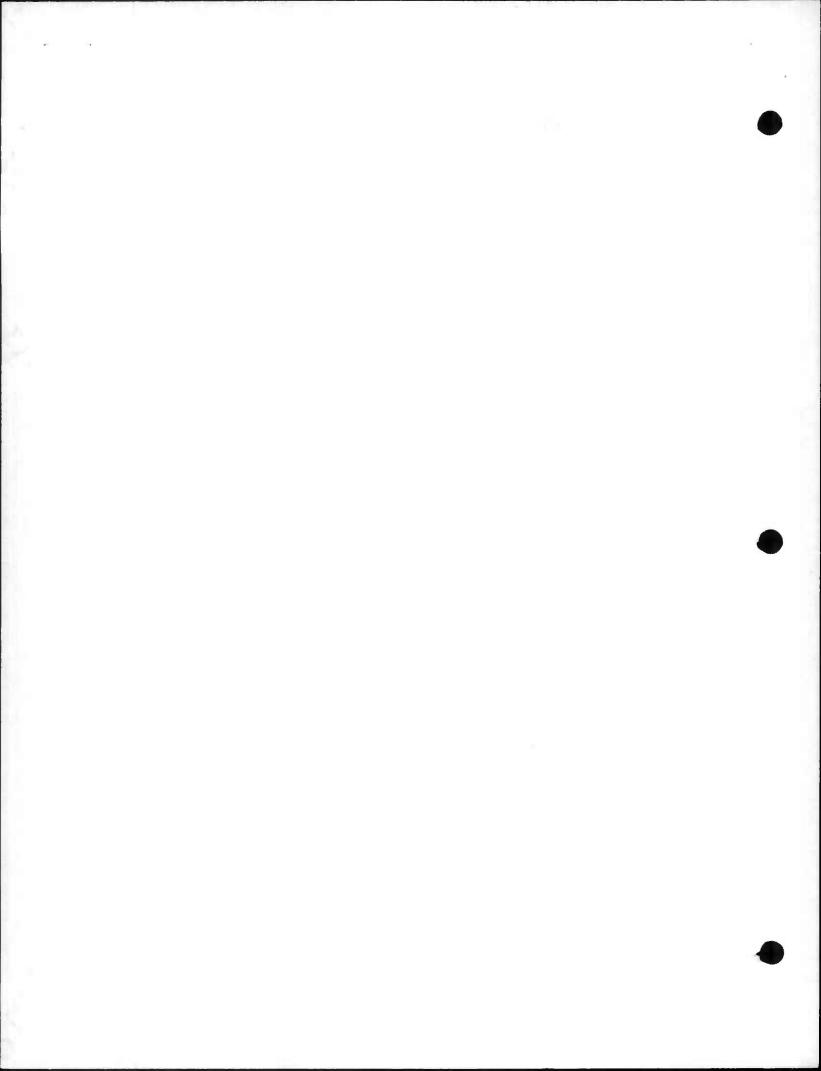
IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Lest) Lest A. SOCIAL SECURITY NUMBER 1. SOCIAL SECURITY NUMBER	. H.	Sch (In yrs. last birthday)	Schaeffer 2. DATE OF DEAM MONTH				S. TIME OF DEATH S. OP 15 QM			
		XM 2 F	74 YRS.	IF UNDER 1 YEAR MONTHS DAYS	F UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) May 9, 19	21	BIRTHPLACE (State or Foreign Country) Maryland			
	9a. FACILITY NAME (If not institution, give street	t and number)	7 7	9b. CITY, TOWN	OR LOCATION OF DE		9c. COUNTY				
0 R	Northwest Hospita	l Center		Rand	allstown		Bali	timore			
EC	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCA	TION			10d, INSIDE CITY			
PIG	Md. Balt	imore		Reister	stown			LIMITS? 1 □ YES 2 NO			
3AL	10e. STREET AND NUMBER			10	1. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?				
FUNERAL DIRECTOR	611 Beverly Road 11. MARITAL STATUS	2. WAS DECEDENT EVER I	NII C ADMED		21136			ISA			
B	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 XXES IF YES, GIVE WAR OR D WW II	2 NO	If yes, sp		NIC ORIGIN? (Specify Yearn, Puerto Rican, atc.) y:		RACE — American Indien, Black, Whita, atc. Specify: White			
	15. DECEDENT'S EDUCATI (Specify only highest grade con	ION npleted)	(Give kind of	USUAL OCCUPATE	ON ost of working	16b. KIND OF BU	SINESS/INDUST	TRY			
PLE	Elementary/Secondary (0-12)	College (1-4 or 8+)	Chana	o rollrod.) L Operati	n #	Cours	tructio	210			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		Cracite	. Ореши		ME (First, Middle, Maiden		711			
BE C	Simon J. Schaeffe	2			Virgin	ria Gill	,				
10	190. INFORMANT'S NAME (Type/Print) Evelyn P. Schaeffe	r				Route Number, City or Tow Sterstown,					
	20s. METHOD OF DISPOSITION 1 V Burlel 2 Cremation 3 Removal 4 Donation 8 Other (Specify)	201	D. PLACE AND DATE	OF DISPOSITION (N	ame of	OATE 20c. LO	CATION — City				
	21. SIGNATURE OF TUNERAL SERVICE LICENS	SEE	u. Zun	22. NAME A	ND ADDRESS OF FA			rstown Road			
	Ham B	Elis	1/	Flino	Funeral	Home Rei	Keisier	own, Md. 21136			
7	23. PART I. Enter the diseases, or com	plications that cause	d the death. Do i	not enter the mo	de of dying, such	h aa cardiac or reapi	ratory arreat,	Approximata			
	IMMEDIATE CAUSE (Final disease or condition										
	disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): PREVIAGRA DE CONSEQUENCE OF):										
NO	Sequentially list conditions,										
EAT	if any, leading to immediate cause. Enter UNDERLYING										
CERTIFICATION	that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	F):							
HH	reaulting in death) LAST										
	PART II. Other algnificent conditions of	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO									
MEDICAL	Aluxe	Cesolio	- 4	an	Accorder	PERFOR		COMPLETION OF CAUSE OF DEATH?			
ME	P/e		HUSION		act tal			1 TYES 2 NO			
AN	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL	UTE TO CAUSE C	26. PLACE OF DEAT		UNCERTAIN						
PHYSICIAN:		OSPITAL:		OTHER:	e 5 🗆 Residence	6 Other (Specify)					
E	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. INJ		28d. DESCRIBE HOW I	NJURY OCCURE	ED			
BY	1 V Natural 5 Pending 2 Accident Investigation			M 1 🗆	YES 2 NO						
ETED	3 Suicide 4 Homicide 8 Could not be datarmined 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28b. LOCATION (Street and Number or Rural Route City or Town, State)							lural floute Number,			
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN ONE) 2 MEDICAL EXAMINER: O							use(a) and manner as stated.			
TO BE	296. SIGNATURE AND TITLE OF CERTIFIER	aun	lux	M	29c. LICENSE NUM	ZZY	PAGE OATE SIG	TYGENED PACKET PROC NEWS			
	516 N. Rolling Roc				lle, Md.	21228		1			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE		·						
	JUL 1 1 1995 Julia	pullula con mand	all					DMAM. 18 Day 1/00			



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		1 - FOR STATE OF MARY	LAND / DEPART			NTAL HYGIEN							
		1. DECEDENT'S NAME (First, Middle, Last) Harry M.	STev	en.S		DATE OF DEATH MONTH D	AY 9 %	S. TIME OF DEATH					
pinous		4. SOCIAL SECURITY NUMBER 5.77-10-2378 5. SEX 6. AGE 5. AGE 5. AGE 5. AGE 5. AGE 6. AGE 6. AGE 5. AGE 5. AGE 5. AGE 6. AGE 6. AGE 6. AGE 5. AGE 6. AGE 6. AGE	81 YRS.	IF UNDER 1 YEAR IONTHS DAYS	HOURS MIN.	pate of Birth (Month, Day, Year) ept 21,	1913	BIRTHPLACE (State or Foreign Country) Florida					
1, 2, 3 st	CTOR	Carroll County General Hospital Westminster Carroll RESIDENCE OF DECEDENT											
Pages	DIRE	Maryland Carroll	10c. CITY,	town on locat Syke	sville		10d. INSIDE CITY LIMITS? 1 YES 23						
n. ansit permit.	ERAL	7309 Second Avenue		101	21784			S.A.					
21215-0020 al or attending physician. for use as the burial-transit	BY FUNER	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER FORCES? 1 YES, GIVE WAR OR I	3 2 NO	If yes, spi	ENDENT OF HISPANIC Of colly Cuban, Maxican, Pt. 2 NO Specify:		or No 14.	RACE — American Indian, Black, White, etc. Specify: White					
21215 al or attend for use as	ETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	16a. DECEDENT'S US (Give kind of wor life. Do NOT use i	rk done during mo:	ON st of working	16b. KIND OF BUS	SINESS/INDUS						
Nospit:	COMPL	12 years 17. FATHER'S NAME (First, Middle, Last)	Clerk &	Interio	r Decorato			Hardware '					
4 8 E	BE C	Harry M. Stevens, Sr.			Annie	(unknow	111						
MA retain 5 sho notifi	2	19a. INFORMANT'S NAME (Type/Print) Mrs. Evelyn Stevens		nifant									
		Mrs. Evelyn Stevens 704 Bonifant Street Silver Springs, MD 2 20a. METHOD OF DISPOSITION 1 Burlal 2 © Cremation 3 Removal from State Complete, crematory or other place) 20b. PLACE AND DATE Of DISPOSITION (Name of Complete, crematory or other place)											
ALTIM death. Page tuneral dire f. examiner r		4 Donetion 6 Other (Specify) Carroll Cremation Ser. 7/10 Hampstead, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
		Burrier-Queen Funeral Directors, P.A. 1212 W Old Liberty Road Winfield, MD 21784											
15 Completely filled in by the fall, cremation, or removal.			ed the death. Do not each line.	t enter the mo	de of dying, auch aa	cardiec or reapi	ratory arreat	Approximata interval Batween Onset and Death					
P.O. BOX 68 th certificate be execute ending physician and c i Hygiene prior to buria or other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b											
AL RECORDS, F e law requires that the death has been signed by the atte Dept, of Health and Mental 123 shows any Injury, (EDICAL	PART II. Other aignificant conditions contributing to death	but not reaulting in	the underlying	cause given in Part	i. 24s. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?					
AL RE e law requ has been Dept. of 1	SICIAN: MI	DID TOBACCO USE CONTRIBUTE TO CAUSE C	OF DEATH YES	_	UNCERTAIN D	4		1 TES 2 NO					
F VIFAL SICIAN: The law certificate has the State Dep	YSICI	EXAMINER? 1 YES 2 NO 1 IN Inpetiant 2 ER/Out		THER:	5 Residence 8 🗆	Other (Specify)							
NG PHYSIC frer this ce sath with the marked,	ву рну	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28b. TIME C	Y WOI		. DEŞCRIBE HOW II	NJURY OCCUR	ED					
TTENDI TTENDI TTOR: A after de 28 is			Y — At home, farm, stre	et, factory, office	281.	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
E Month	COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my know one) 2 MEDICAL EXAMINER: On the best of examination						use(s) and manner as stated					
TO THE HOSPITAL TO THE FUNERAL be filed within 72 IMPORTANT: If	BE	296. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUMBER			GNED (Month, Day, Year)					
E 0 - 1	5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DI					1015						
		Philip Konits 2059 Ba 31. Date FileD (Month, Day, Mar) 32. REGISTRAR'S ST	lltimore Bl	LVd.	Finksburg	, ми 2	1048						



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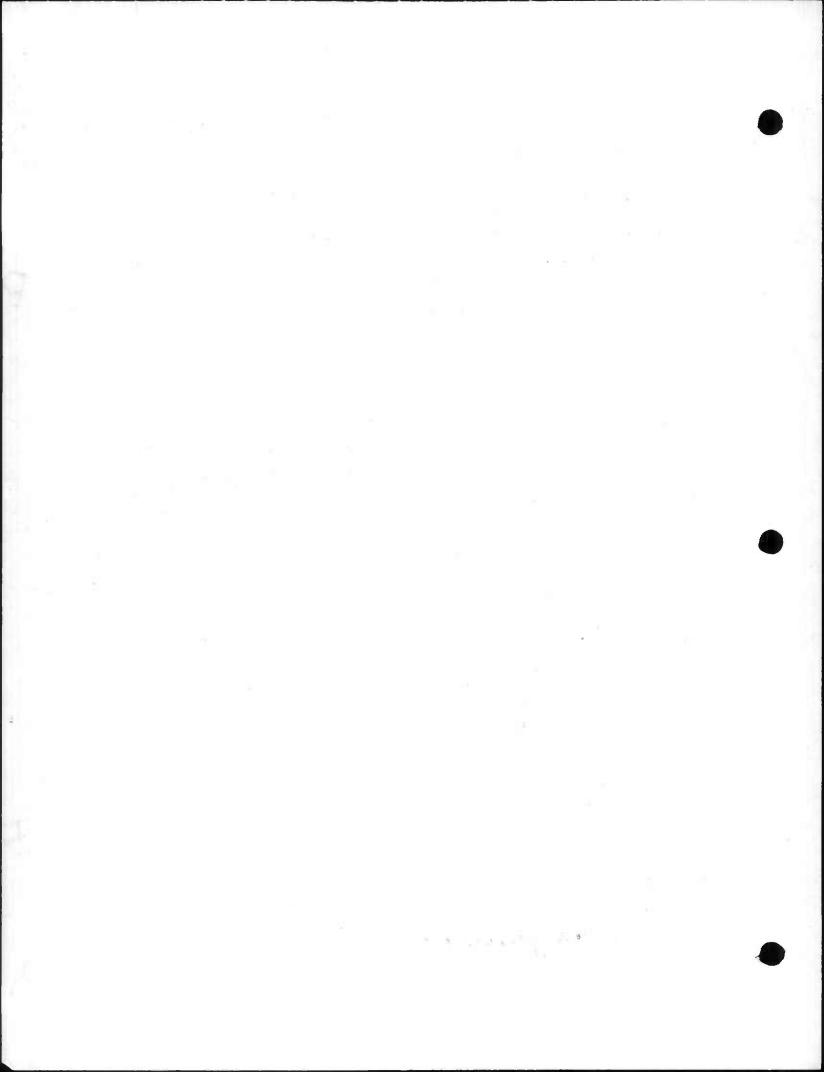
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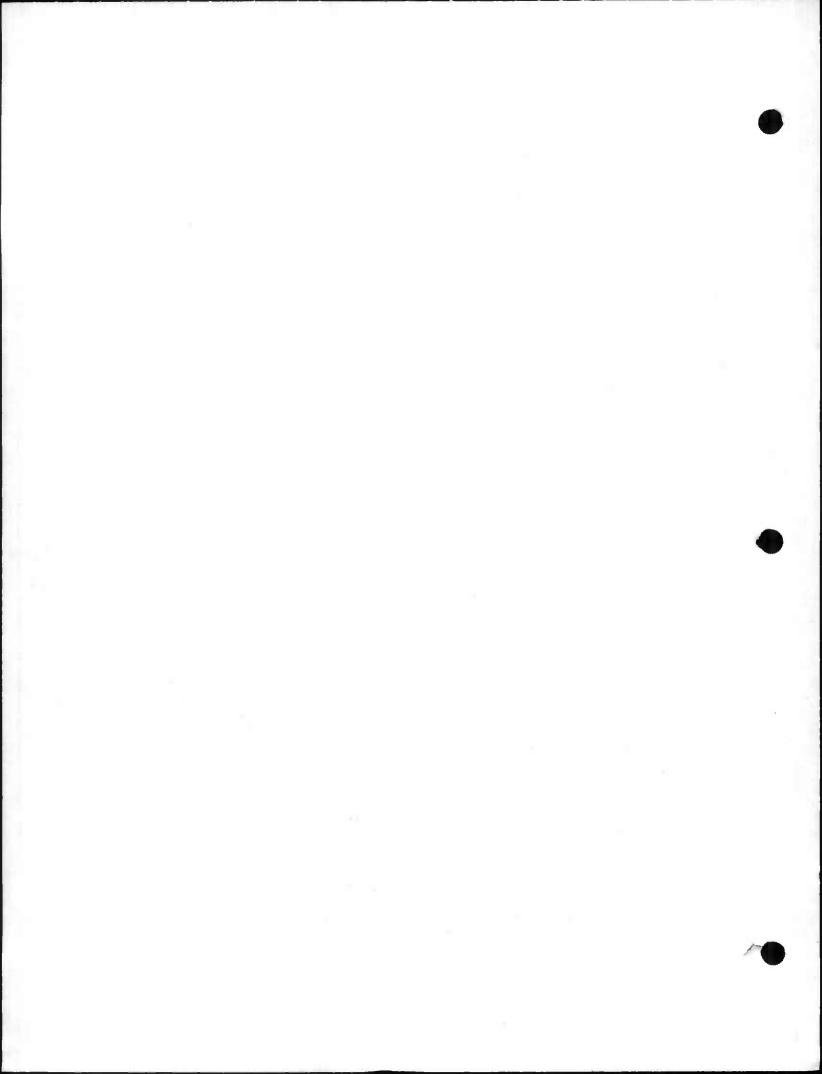
FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

	1 - STATE REGISTRAR	STATE OF M							ENTAL HYGIEN REG. NO.	Е		
1. DECEDENT'S NAME (First, Middle, Last) REPNADD SAKS 2. DATE OF DEATH MONTH DAY											3. TIME OF DEATH	
	100 14 0000	XM 2 F	6. AGE (In yrs. last 71		IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTN (Month, Day, Year)		8. BIRTH Count	IPLACE (State or Foreign
	9a. FACILITY NAME (If not institution, give stree		7.1	YRS.	0 0 0 T	701101			FEB. 4,19			YORK
Œ		t end number)			96. CITY			ON OF DEAT	тн	9c. COU	NTY OF D	
DIRECTOR	STNAT HOSPITAL					BAL	TIMO	RE				N/A
HE	10s. STATE 10s. COUNTY			10c. CIT	Y, TOWN (OR LOCATI	ON					10d. INSIDE CITY LIMITS?
LD	MARYLAND BALT 100. STREET AND NUMBER	IMORE			WC	ODLA	WN ZIP CODE					1 - YES 2 X NO
FUNERAL	5-A TORLINA COUR	T				101.		1207		10g. CII		WHAT COUNTRY?
3	11. MARITAL STATUS		EVER IN U.S. ARM		13.	WAS DECI	ENDENT O	F HISPANIC	ORIGIN? (Specify Yes	or No-	USA 14. RACI	E — Americen Indian, k, White, etc.
ВУ Е	1 Never Married 2 Merried 3 Widowed XX Divorced	IF YES, GIVE WI	YES 2 NO	0		If yee, spe 1 TES	city Cuber 2NO	n, Mexican, Specify:	Puerto Rican, etc.)		Spec	
	15. DECEDENT'S EDUCAT	104	WWII-AR									WHITE
	(Specify only highest grade cor		(Giv	w kind of v	work done is retired.)	during mos	N it of working	g	16b. KIND OF BUS	INESS/IN	DUSTRY	
APL	Lientenan processing (0-12)	4		CLAI	MS E	IMAX	NER		SOCI	IAL S	SECUE	RITY
COMPLETED	17. FATHER'S NAME (First, Middle, Last)								E (First, Middle, Meiden	Surname)		
B	MAX 19e. INFORMANT'S NAME (Type/Print)			AKS				ELLA			JUD1	TZ
2	MR. HOWARD	SAF							ute Number, City or Town			226
	20a. METHOD OF DISPOSITION		20b. PLACE A	ND DATE (OF DISPOS	ITION (Nar	ne of		DATE 20c, LOC	CATION —	City or To	wn, State
	1 Donation 5 Other (Specify)		HILL	TOP	"SERV	ICE	CORP	- 7-	10-1995	rows(ON, N	1D
	21. SIGNATURE OF FUNERAL SERVICE LICEN		~ ~ ~		22.	NAME AN	EVIN	S OF FACIL	& BROS.,	INC.		MD 21215
	• ullmu	devi	5, 65				6	010 I	REISTERST	NWC		BALTIMORE,
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, ahock, or heart failure. List only one ceuse on each line. Approximate interval Between											
	iMMEDIATE CAUSE (Final disease or condition	501	1415									Onaat and Death
1	resulting in death) a	DUE TO	OR AS A CONSECU	JENCE OF	F):							
Z												
ATIO	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING	DUE TO (OR AS A CONSEQU	JENCE OF	F):							
FIC	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONSECU	JENCE OF	F):					-		
CERTIFICATION	reaulting in death) LAST											
	PART ii. Other algnificent conditions of	ontributing to d	leath but pot re	suitino I	n the un	derivino	cause o	iven in Pa	ert I. 24s. WAS AN	ALITOPSV	246	WERE AUTOPSY FINDINGS
ICAL		woon	lula		ne	Sul	in	-de	PERFOR	MED?	1	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MED	dialeter mellite	12, rene	Maril	un	2.				1 🗆 YES 2	MO		DF DEATH?
	DID TOBACCO USE CONTRIB	BUTÉ TO CAL	JSE OF DEAT	H YE	S 🗆 1	10 D	UNC	ERTAIN				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINERS	OSPITAL:	26. PLACE	OF DEAT	OTHER							
IYS	1 TYES 2 NO 1	Inpatient 2 🗆	ER/Outpatient 3		4 🗆 Nun	lng Nome			Other (Specify)			
	1 Netural 5 Pending	(Month, Day		26b, TIM	URY M	28c. INJU WOF	IRY AT IK? ES 2 🗌		lad. DESCRIBE HOW IN	JURY OC	CURED	
Э ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF	JNJURY — At hom	e, ferm, s	treet, fact				281. LOCATION (Street end Number or Rural Route Number,			
COMPLETED	4 Nomicide determined	bollong, e	tc. (Specify)						City or Town, State)			
3	29e. CERTIFIER (Check only one)											
S	2 MEDICAL EXAMINER: C	On the baels of exa	mination end/or in	vestigatio	n, in my o	pinion, de	ath occure	ed et the tin	ne, date end place, end	due to th	ne ceuse(e) end menner se stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER	1. W	T			450	29c. LICE	12 L	Thomas	29d. DAT	E SIONED	(Month, Day, Year)
2	30. MAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE	OF DEATH (ITEM	27) (Trope	Print1	133	-10 6	クレー	15177/		11	473
	10. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. JENNIFER PARK											
	Tinoi HOSO	2401	4) he	vea	ere	2	E	Do	Mild re	MD	21	21
	31. DATE FILED (MONTH), Day, Year) JUL 1 1 1995 9	2401	s SIGNATURE	vea	en	2/1	e	De	mare	MD	21	215



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		FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF I		MENTAL HYGIE				
		1. DECEDENT'S NAME (First, Middle, La.					2. DATE OF DEATH		YEAR 3.	TIME OF DEATH	
		Edward Sc	7.199		6:10 QH						
P		4. SOCIAL SECURITY NUMBER 219 56 5640	1 M 2 🗆 F	(In yrs. last birthday, 44 yrs.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	1950	Country) MARY	ACE (State or Foreign LAND	
2, 3 should	стоя	Baltimare Vet	ran's Affairs	tospital	/ / /	DR LOCATION OF D			TIMOR	RE CITY	
Pages 1,	DIREC	RESIDENCE OF DECEDENT 10a. STATE 10b. COU MARYLAND BA	NTY ALTIMORE	10c. CI	TY, TOWN OR LOCA	BALTIM	ORF			d. INSIDE CITY	
t permit.	RAL	10a, STREET AND NUMBER			10	of. ZIP CDDE		10g. CITIZI		T COUNTRY?	
020 physician. burial-transit	LUI I	3920 BENSON AVEN				21229			U.S.A		
5-0020 nding physician. as the burial-trar	BY FUN	1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1X YES IF YES, GIVE WAR OR D VIE	a Claum	If yes, s		NIC ORIGIN? (Specify Youn, Puerto Rican, etc.) y:	is or No— 1	Black, W Specify:	American Indian, thita, atc. WHITE	
r afte	ETED	15. DECEDENT'S E (Specify only highest gri	DUCATION ade completed)	18a. DECEDENT	S USUAL OCCUPATI work done during muse retired.)		16b. KIND OF BI	USINESS/INDU		WILLE	
ND 2 hospital of ached for	OMPLE	Elementary/Secondary (0-12) H/S GRAD	College (1-4 or 5+)	ELECTI			ELECTR	IC UNI	ON #2	4	
AND the hospital detached for once.	CON	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Maide		011 112		
8 2 Z	BE (ANTHONY W. SCHNE	IDER								
MA retain 5 sho	10	190. INFORMANT'S NAME (Type/Print) JOANN MEEKINS					Acute Number, City or To ELLICOTT			21042	
6 may stor, pa		20s. METHOD OF DISPOSITION 1									
		21. SIGNATURE OF FUNERAL SERVICE			22. NAME A	NO ADDRESS OF FA	CILITY				
BALTIN BALTIN ter death. Pag the funeral di val.		Jours ?	Smill		4107	WILKENS	AL HOME, AVENUE-BA	LTIMOR		21229	
hours after ed in by the or removal		23. PART t. Enter the diseases, o shock, or hasrt fallur	or complications that cause e. List only one cause on e	d the death, Do each iine.	not entar tha mo	ode of dying, suc	h aa cardisc or resp	piretory arres	st,	Approximata interval Between	
# 5 B		MMEDIATE CAUSE (Final disease or condition resulting in death) a. Widespread tumor motostasis 21 days									
ted within completely ial, cremati event, t		DUE TO (OR AS A CONSEDUENCE OF):								- Totaly s	
A 62 n and to bur	TION	disease or condition resulting in death) a. Widespread tumor metastasis Due to (or as a conseduence of): Sequentially list conditions, If sny, leading to immediate Due to (or as a conseduence of):									
	FICATIO	cause. Enter UNDERLYING CAUSE (Disesse or injury that initisted events	cDUE TO (OR AS A	CONSEQUENCE	DF):						
P Holina	ERTI	0.									
5 4 5 E	AL C	PART ii. Other significant conditi	ions contributing to death b	out not resulting	in tha underlyin	g csuse given in	Part I. 24a, WAS AI		24b. WE	RE AUTOPSY FINDINGS	
S = G = C	MEDICA						PERFO		OF	MARLE PRIOR TO MPLETION OF CAUSE OEATN?	
S of Lee	. M	DID TOBACCO USE CON	ITRIBUTE TO CAUSE O	F DEATH Y	ES [] NO [UNCERTAIL	<u> </u>		1 [YES 2 ND	
4: The law cate has bestate Dept.	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			TH (Check only one)		· /P4				
SICIAN: The Certificate the State	YSI	1 TYES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outp	petient 3 DOA	OTHER: 4 - Nursing Hon	ne 5 🗆 Rasidence	8 Other (Specify)				
F si si si si si si si si si si si si si	ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TII	JURY WO	JURY AT ORK? YES 2 NO	28d. DESCRIBE HOW	INJURY OCCU	REO		
TTENDI TTENDI TTOR: A affer de	8	3 Suicide 8 Could not b 4 Homicide datarmined	28s. PLACE OF INJURY building, stc. (Spec	— At home, term,	street, factory, offic		28f. LOCATION (Street City or Town, State	and Number or	Rural Route	Number,	
	COMPLET		YSICIAN: To the bast of my know								
	00	2 MEDICAL EXAMI	NER: On the basis of exemination	n and/or investigati	on, in my opinion, d	lesth occured at the	time, data and placa, a	nd dua to the	cause(s) and	f manner as stated.	
五 五 五 五 五 五 五 五 五 五 五 五 五 五 五 五 五 五 五	8	29% BIGNATURE AND TITLE OF CERTAIN	VER PLON MA	\sim		29c. LICENSE NUI	ABER TOE	29d. DATE S	SIGNEO (Mo	nth, Day, Year)	
222	٩	Balle AND ADDRESS DF PERSON V	WHD COMPLETED CAUSE OF OR			INDO	170-7	1-74	y 7	,1993	
		31. DATE FILED (Month, Day, Year)	Tron's 17 th		uspital	10 N. C	rreen St.	Balt	more	MD21201	
场十一		JUL 1 1 1995	The state of the s								



YEAR

9c. COUNTY OF DEATN

MD

10g. CITIZEN OF WHAT COUNTRY?

White

U.S.A.

3. TIME OF DEATN

8. BIRTNPLACE (State or Foreign

10d. INSIDE CITY

14. RACE — American Indien, Black, White, etc.

1 YES 2 NO

Approximate Interval Between

24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO

1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

600 N. Wolfe St., Baltimore 21287

07/07/95

COMPLETION OF CAUSE

Onset and Death

3 HOURS

2:25 p

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2. DATE OF DEATN **JEROME** ZYMANSKI JULY 5,1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year DAYS HOURS 212-36-4990 1 M 2 F 54 10/2/1940 permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MD Baltimore City FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 136 N. Streeper St. burial-transit 21224 Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yee, specify Cuben, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 1 Never Married 2 Merried ΒY 3 Widowed 4 Divorced the funeral director, page 5 should be detached for use as the ED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) Unk. Busdriver Transportation 12 notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Angeline Gostomski Edward Szymanski 38 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 403 Whitaker Mill Rd. Fallston, MD 21047 Joseph Szymanski 9 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 1 Buriel 2 Cremetion 3 Removel from State
4 Donetion 5 Other (Specify) Sacred Heart of Mary Cem. 7/8 Baltimore Cntv. MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE B. Dabrowski & Son Funeral Home hours after death. 4 2818 E. Baltimore St. Baltimore, MD 21224 medicai 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. signed by the attending physician and completely filled in by Health and Mental Hygiene prior to burial, cremation, or remo IMMEDIATE CAUSE (Final the disease or condition executed within 24 PROBABLE MYDIARDIAL INFARCTION reaulting in death) traumatic event. DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF). that initiated events reaulting in death) LAST 0 injury. PART II. Other aignificant conditions contributing to death but not reaulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL any HYPERTENSION 1 YES 2 NO Shows this certificate has been with the State Dept. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{2}\) PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 I DOA Ing Home 5 Residence 6 Other (Specify) 0 27. MANNEB OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b, TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Netural м 1 YES 2 NO After ti BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 90 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be DIRECTOR after 200 4 Nomicide hours item 8 29e. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) end menner se stated. FUNERAL I within 72 h TO THE HOSPITA
TO THE FUNERA
De filed within 7. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and manner se stated.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

29c. LICENSE NUMBER

M0809

Emergency medicine

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

BE

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29b. SIGNATURE AND TITLE OF CERTIFIER

Jean

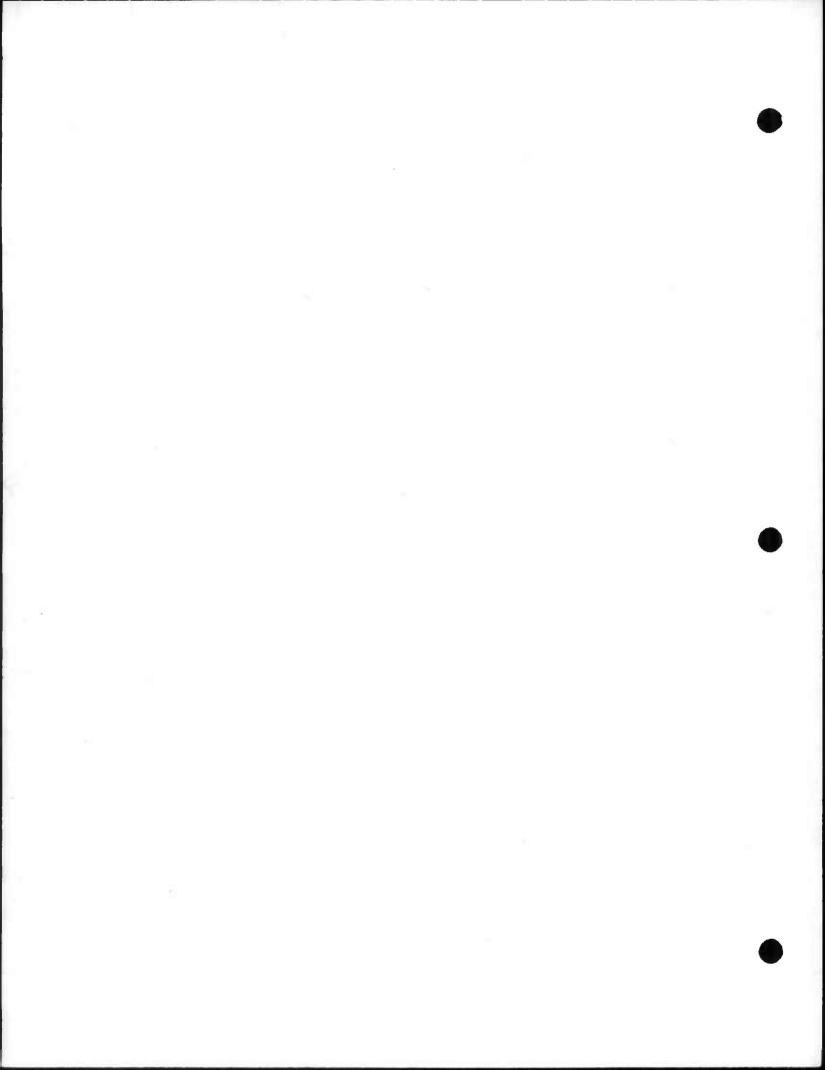
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Ling, MD

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Department of

July 32 De Land Lans SIGNATUR



1995

1-29-95

NATIONAL NAVAL MEDICAL CENTER

BETHESDA, MD 20889-5600

27

3. TIME OF DEATH

10:30

Approximate intarvsi Batween **Onset and Death**

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 - STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

JEANNE

4. SOCIAL SECURITY NUMBER

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	On oversions business The co
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	1	4. SOCIAL SECURITY NUM		5. SEX	8. AGE ('In yrs. lasi	birthday)		R 1 YEAR	IF UNDER		7. DATE OF				PLACE (State or Foreign
		197-34-3849	1 □ M 2 📉 F	66 YRS.			DAYS	NOV.13,19				28 JAPAN				
		9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH											EATH			
burial-transit permit. Pages 1, 2, 3 should	OH	NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY										1ERY				
	5	RESIDENCE OF DE	10b. COUNTY	,			10 - CIT	Y, TOWN	OD 1 004							
	E	WV		ELEY												10d. INSIDE CITY LIMITS?
		10e. STREET AND NUMBER		E L E I			IV.	IART 1								1 YES 2 NO
	RA	111 TAMMY							10	f. ZIP CODE						VHAT COUNTRY?
	FUNERAL	11. MARITAL STATUS	LANE	12 WHE DECEDED	IT FUED II	1110 400		1.0		254						. A.
	Β¥	1 Never Married 2 3 3 Widowed 4 Dive	_	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	I YES	2 X N	O	13.	If yea, sp	ecify Cubs	n, Mexican	C ORIGIN? (5 , Puarto Rica	specify Yes in, atc.)	or No-	14. RACE Black Speci	E — American Indian, s, Whita, atc. fy: ASIAN
	ED	15. DEC	EDENT'S EDU	CATION		18a. DE0	EDENT'S	USUAL C	CCUPATION	ON		16b. Ki	ND OF BUS	SINESS/IND	USTRY	
		Elementary/Secondary (College (1-4 or 5	+)	life.	Do NOT u	sa retired.)	duning mo	st of workin	g					
eš	₹ I	12		4		D	ESIG	NER				I	DRESS	MAKE	R	
76	BE COMPLET	17. FATHER'S NAME (First, A INNOSUKE IM										IKEDA		Surname)		
	0	19a. INFORMANT'S NAME (Type/Print)			19b	. MAILING	ADDRES	S (Street a	ind Number	or Rural Ac	oute Number,	City or Tow	n, State, Zip	Code)	
		MR. HUGH ST	REHLE				111	TAMM	IY LA	ANE,	MART	INSBU	RG, V	VV 25	401	
must be		20a METHOD OF DISPOSIT	ION	oval from State	20b	PLACEA	ND DATE	OF DISPO	SITION (Na	anie of		DATE	20c. LO	CATION —	Ofty or To	wn, Stata
Ē		4 Donation 5 Other	(Specify)		A	RLIN	GTON	NAT	'IONA	AL CE	Μ.	7/3	ARI	INGT	ON,	VA
examiner		≥ Char	les les	M. L	Bio	w	U	B	ROWN	ND ADDRES	ERAL	HOME MARTII	, 327 NSBUR	7 W. 1	KING V 25	ST.
traumatic event, the medical	CERTIFICATION	immediate cause (Fidelease or condition resulting in death) Sequentially list condit if any, leading to immediate. Enter UNDERLY CAUSE (Disease or inju	ions, dieta	b		C CAI	NCER UENCE O									interval Betwe
J. OI OILO	CERTIFI	that initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):														
	MEDICAL (PART ii. Other algnifica	int condition	s contributing to	death b	ut not re	eaulting	n the u	ndarlyin	g cause g	jiven in P		PERFOR	MED?	24b.	WERE AUTOPSY FINDING AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
3 shows	=	DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE O	F DEAT	H YE	S 🗆	NO [1 UNC	ERTAIN	Ital				· les · M
em 23	CIAN:	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL			26. PLACE			_			A.L.			1	
	Sic	1 TES 2 NO		HOSPITAL:	ER/Outp	atient 3	DOA	OTHER		a 5 🗆 Re	sidence 8	☐ Other (S)	necify)			
d, or	PHYSIC	27. MANNER OF DEATH	F 191	28a. DATE OF (Month, D	INJURY		28b. TIM		28c. INJ	URY AT		28d. DESCRI		JURY OCC	URED	
	BY F		Pending Investigation	(Month, D	ray, rear)		INJ	M		RK? YES 2 _] NO					
3 Suicide 8 Could not be determined 28s. PLACE OF INJURY — Ai home, farm, streat, factory, office 28s. LOCATION (Street and Number or City or Town, State)							or Rural R	oute Number,								
MPURIANI: IT ITEM	COMPLET			CIAN: To the best of a												and manner as stated.
	O P	296. SIGNATURE AND TITLE									NSE NUME					(Month, Day, Year)
		N Jel Mo							VA 0101-050077 ► (-29-95							
	CO III															

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MC. USNR

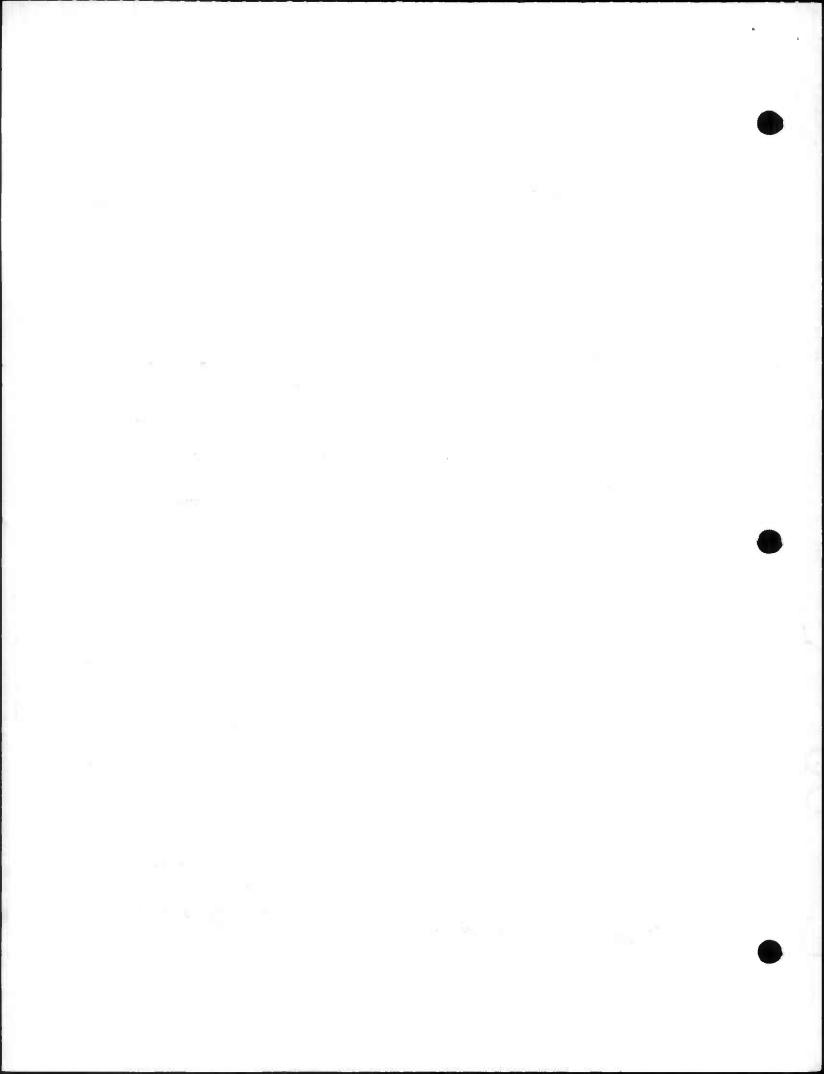
NORMAN LEE, LT.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

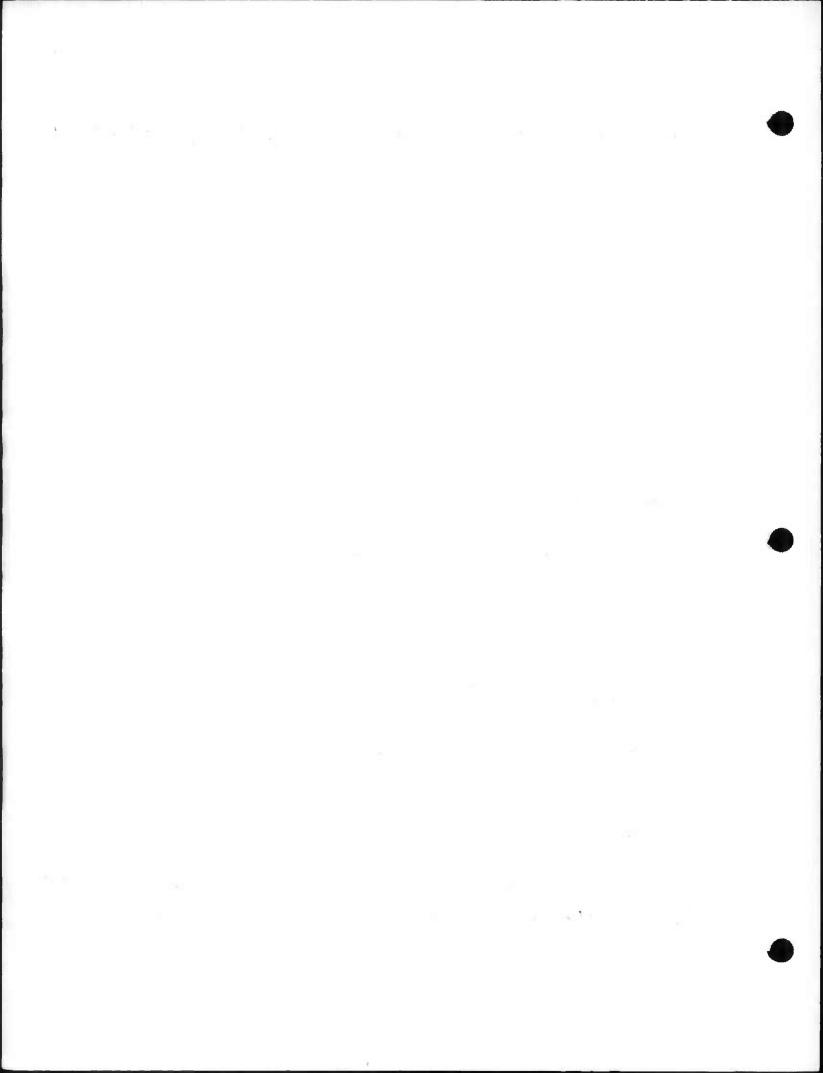
2. DATE OF DEATH

JUNE



rySICIAN: The law requires that the death certificate be executed within 2 mours after death, Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dect. of Health and Mental Hydiene prior to burial, cremation, or removal.	ked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physical within 72 hours after death with the State Deot, of Health and Mental Hydiene by	70

		T OF HEALTH AND MENTAL HYGIENE E OF DEATH REG. NO.							
1	VIRGINIA M. TABB	2. DATE OF DEATH JULY 7 1995 1:05 PM							
	4. SOCIAL SECURITY NUMBER S. SEX 8. AGE (in yrs. lest birthdey) FUNDE MONTHS MONTHS	RT 1 YEAR IF UNDER 24 HRS. 7. OATE OF BIRTH (Month, Day, Year) Sept 4, 1907 S. BIRTHPLACE (State or Foreign Country) Md							
OR	Deaton Specialty Hospital	TY, TOWN OR LOCATION OF OBATH Sc. COUNTY OF OBATH OUT OF OBATH							
DIRECTOR	100. COUNTY 100. COUNTY 100. COUNTY 100. CITA TOWN	OR LOCATION - 10d. INSIDE CITY LIMITS? 1 YES 2 NO							
FUNERAL D	10. STREET AND NUMBER 6428 Sewell Orchard Dr.	101. ZIP CODE 109. CITIZEN OF WHAT COUNTRY?							
BY FUNE		I. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— I1. RACE — American Indian, II yea, specify Cuban, Mexican, Puerto Rican, etc.) 1 — YES 2 IX NO Specify: Specify: Source							
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)	OCCUPATION 196. KIND OF BUSINESS/INDUSTRY							
	17. Forther's NAME (First, Middle, Leat) Tohnson	18. MOTHER'S NAME (First, Middle, Maiden Surname) SUSIE DAUS							
TO BE	190. INFORMANT'S NAME (Type/Print) Franklin 6428	SS (Street and Number or Aural Route Number, City or Rown, State, Zip Code) Sewells Orchard Dr. Columbia, 2104							
	20e, METHOD OF DISPOSITION 1 DS. Burlal 2 Cremation 3 Removal from State 20e PLACE OF DISPOSITION (Name of cometer), crematory or 17/3 Ba to, and 20e Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 23. NAME AND ADDRESS OF FACILITY 24. NAME AND ADDRESS OF FACILITY 25. NAME AND ADDRESS OF FACILITY 26. LOCATION - City or Town, State 27/3 Ba to, and 27/3 Ba to, and 28. NAME AND ADDRESS OF FACILITY 29. NAME AND ADDRESS OF FACILITY 29. NAME AND ADDRESS OF FACILITY 29. NAME AND ADDRESS OF FACILITY 29. NAME AND ADDRESS OF FACILITY 29. NAME AND ADDRESS OF FACILITY 29. NAME AND ADDRESS OF FACILITY 29. NAME AND ADDRESS OF FACILITY 29. NAME AND ADDRESS OF FACILITY 29. NAME AND ADDRESS OF FACILITY 29. NAME AND ADDRESS OF FACILITY 29. NAME AND ADDRESS OF FACILITY 29. NAME AND ADDRESS OF FACILITY 29. NAME AND ADDRESS OF FACILITY 29. NAME AND ADDRESS OF FACILITY 29. NAME AND ADDRESS OF FACILITY								
	23. PART L Enter the dealeses, or complications that ceused the deeth. Do not enter the mode of dying, such se cerdisc or respiratory errest, shock, or heart feliure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. ATHENOSCIENT IC CARDIOVASCULAR DISEASE								
CERTIFICATION	Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								
PHYSICIAN: MEDICAL CI	PART II. Other significent conditions contributing to deeth but not resulting in the s ALDHEIMER'S DEMENTIA PER VASCULAR DISEASE	underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 21 NO 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO							
ICIAN:	25. WAS CASE REFERREO TO MEDICAL EXAMINER? HOSPITAL: QTHI	26. PLACE OF OEATH (Check only one) ER:							
	1	ursing Home 5 Residence 6 Other (Specify) 28c, INJURY AT WORK? 28d, DE\$CRIBE HOW INJURY OCCURED							
FED BY	2 Accident Investigation 3 Suicide 5 Could not be detarmined 25e. PLACE OF INJURY — At home, farm, street, fa	actory, office 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my	e time, data and place, and dua to the cause(a) and manner as stated. y opinion, death occured at the time, data and place, and dua to the cause(a) and manner as stated.							
BE	296. BIODITURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER 28d. DATE SIGNED (Month, Day, 19ar) D 3//3 6 JULY 7, 1995							
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Typo, Print) BLANC WALLACE MD CII S. C	D3/136 ETULY 7, 1995 2 HALLES ST., BALTIMME MAD 2/230							
	3. JULI 17 1995" Juli Substitute								



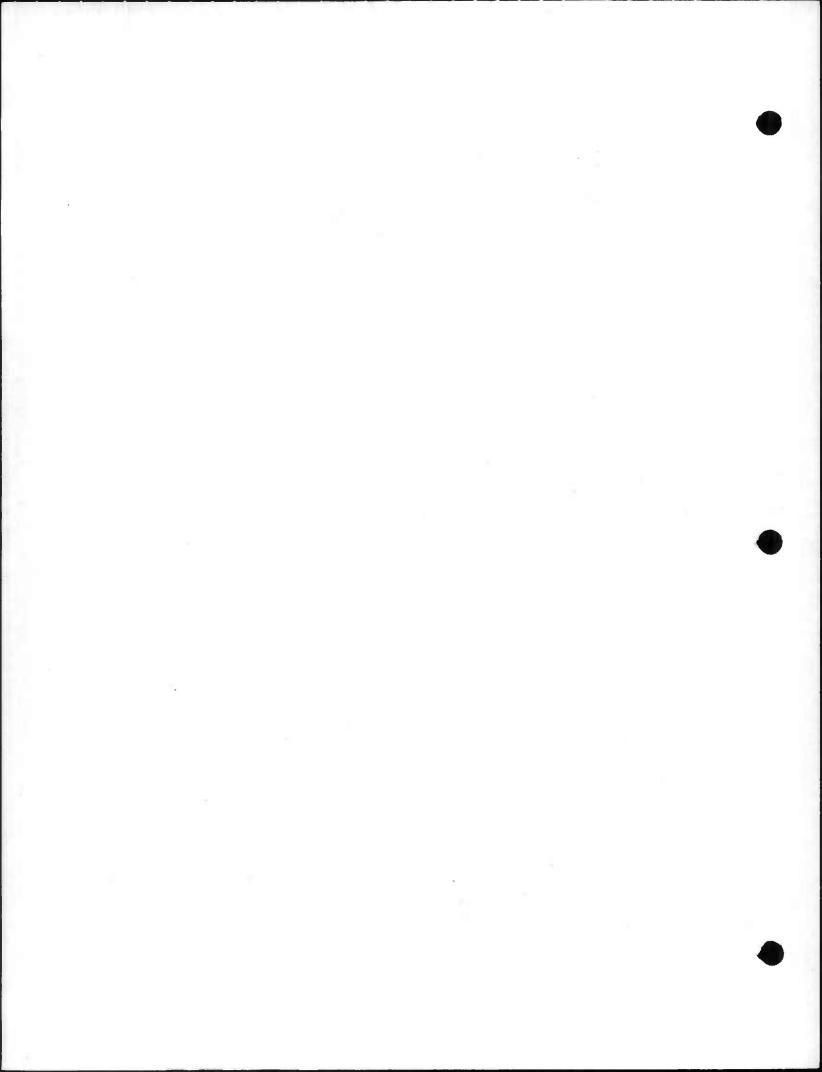
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DIVISION OF VITAL RECORDS,	¢
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within or hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netitled at once. BALTIMORE, MARYLAND 21215-0020 TO BE COMPLETED TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	1 - STATE REGISTRAR			ENT OF HEALTH AND ATE OF DEATH	MENTAL HYG	_			
	1. DECEDENT'S NAME (First, Middle, Last)		7	Thomas	2. DATE OF DEAT	Н	3. TIME OF DEATH		
1	4. SOCIAL SECURITY NUMBER 213-32-4766	10 M 2 MF 59		UNDER 1 YEAR # UNDER 24 HRS. ITHE DAYS HOURE MIN.	JUNE OF BIRTH	nr)	BIRTHPLACE (State or Foreign Country)		
ECIOH	9a. FACILITY NAME (If not institution, give s. 214 N. Denn. RESIDENCE OF DECEDENT	ustreet and number) USON Street	et 96.	Baltimure	DEATH	9c. COUNTY	Y OF DEATH		
DIMEC	10a. STATE 10b. COUNTY	IA	10c. CITY, TO	OWN OR LOCATION			10d. INSIDE CITY LIMITS? 1 X YES 2 NO		
UNERAL	100 STREET AND NUMBER 214 A. Denis	ion Street	+	101. ZIP CODE 2/22	9	10g. CITIZEI	N OF WHAT COUNTRY?		
BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	MNO	13. WAS DECENDENT OF HISP, If yes, specify Cuban, Maxic 1 VES 2 NO Specific	can, Puerto Rican, etc	y Yes or No— 14	Black, White, atc. Specify: Black		
LEIEU	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	n. DECEDENT'S USUA (Give kind of work of life. Do NOT use retir	done during most of working ired.)	16b, KIND OF	BUSINESS/INDUS			
E COMP	17 FATHER'S NAME (First, Middle, Last) Drew Ogles	N/A	JCIT-	18, MOTHER'S N	NAME (First, Middle, Ma	1	•		
20	199. INFORMANT'S NAME (Typa(Baint)	mas	196. MAILING ADDI 214	PRESS (Street and Number or Rum		Town, State, Zip Co	ode)		
	28a/METHOD OF DISPOSITION 1 Suburlal 2 Cremation 3 Remark 4 Donation 5 Other (Specify)	celhelery	ACE AND DATE OF DIS	SPOSITION (Name of Helper) K. C. C. C. C. C. C. C. C. C. C. C. C. C.	DATE 200	LOGATION - CITY	y or Town, State 7, Ad		
	21. SIGNATURE OF FUNERAL SERVICE LIC	- D- Aco	X	March F. H. W 14300 Wa	bach Ace	nue Ba	rish and zizis		
		complications that caused the List only one cause on each i	desth. Do not e	nter the mode of dying, su	ich as cardiec or n	eapiratory scress	t, Approximate interval Between		
	immediate Cause (Fine) disease or condition resulting in deeth) a. Hepatic Failure								
	DUE TO (OR AS A CONSEQUENCE OF): LIVEY Metas force / month								
	Sequentially list conditions, if any, lesding to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): Print								
- Luising	CAUSE (Disease or injury that initiated events resulting in deeth) LAST								
2	PART II. Other aignificant condition	e contributing to deeth but n	ot resulting in th	e underlying cause given in		B AN AUTOPSY	24b. WERE AUTOPSY FINDINGS		
NEDIO S						S 2 NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
	DID TOBACCO USE CONTR				IN 🗆				
	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	26. Pl HOSPITAL: 1 Inpetient 2 ER/Outpetient		HER:	* C Other (Parallel				
	27. MANNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	Nursing Homa 5/1 Rasidence 26c, INJURY AT WORK?	6 Other (Specify) 28d. DESCRIBE HO	OW INJURY OCCUR	RED		
	1 Natural 5 Pending 2 Accident Investigation		'	M 1 YES 2 NO					
	3 Suicide 8 Could not be detarmined	28s. PLACE OF INJURY — As building, atc. (Specify)			City or Town, S	itate)	Rural Route Number,		
	2 MEDICAL EXAMINE	ICIAN: To the best of my knowledge, ER: On the besis of examination and							
	296. SIGNATURE AND TITLE OF CENTIFIER	alexed Mi		29c. LICENSE NU			IGNED (Month, Day, Year)		
	30. NAME AND ADDRESS OF PERSON WHO	1///	TEM 27) (Type, Print)	Balt M	rd 212	rg			
	JUL 1 1995 Jul	32. REGISTRAR'S SIGNATURE	E						



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should importANT: If Item 28 is marked, or item 23 shows any injury or other transmalls were? The marked is marked, or item 23 shows any injury or other transmalls were?

			95	20300			
		Item1, Film725, 7/13/95, 1t					
		1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIEN CERTIFICATE OF DEATH REG, NO					
Г		1. DECEDENT'S NAME (First, Middle, Last) JAMES DAVIS TRAYNHAM, Jr 2. DATE OF DEATH		3. TIME OF DEATH			
1		July July	7 199	DS 1.16 AM			
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7, DATE OF BIRTH	8.	BIRTHPLACE (State or Foreign			
		193-54-4155 10 M 2 0 F 3 YRS. MONTHS DAYS HOURS MIN. (MONTH, Day, Year)	1964	Country			
		9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN) OR LOCATION OF DEATH	9c. COUNTY,	OF DEATH			
	8	Maniand Veneral Mospita 12alto	N	117			
	딦	RESIDENCE OF DECEDENT 10q. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY			
ı	DIRECTOR	md NA Balto		LIMITS?			
		10s. STREET AND NUMBER 10f. ZIP CODE	10g. CITIZEN	OF WHAT COUNTRY?			
	FUNERAL	119 Lynhurst St. 21229	L	1.5.A			
	5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMENT OF HISPANIC ORIGIN? (Specify Yes) 14. Never Married 2 Magnet FORCES? 1 YES 2 NO If yes, specify Quiben, Mexican, Puerto Rican, etc.)	s or No- 14.	RACE — American Indian,			
	BY	1 Never Married 2 Married FORCES? 1 YES 2 NO If yes, specify Juben, Mexican, Puarto Rican, etc.) 3 Widowed 4 Divorced 1 YES 2 NO Specify:		Black, White, etc. Specify: Q			
	60		- 1	DIACK			
	ETE	(Specify only highest grade completed) (Give kind of work done during most of working	SINESS/INDUST	RY			
	립	Elementary/Secondary (0-12) College (1-4 or 5 +) Factor Worker to	acto	ry			
	COMPL	17, FATHER'S NAME (First, Middle, Lest) . 10. MOTHER'S NAME (First, Middle, Melden	Sumafile) .)			
6	ш	James Davis Traynham 2r. Emestine	Thin	es			
	10 8	199_MFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, CN) or Tow	rn, State, Zip Coo	(6)			
	-	Conestine Traylam 5107 Williston St. Da	10,1	nd 21229			
		Burial 2 Cremation 3 Ramoval from State crematory or differ Nace	CATION - City	or Town, Stata			
		A Donation 5 Other (Specify)	and	alls town, tho			
	i	22. NAME AND ADDRESS OF FACILITY 22. NAME AND ADDRESS OF FACILITY 22. NAME AND ADDRESS OF FACILITY					
		13 Deou 124300 Wabash	Ave				
		23. PART I. Enter the disease, or complicatione that caused the deeth. Do not enter the mode of dying, such as cerdiec or respishock, or heen sellure. List only one cause on each line.	iretory arrest,	Approximata Interval Between			
	- 1	IMMEDIATE CAUSE (Final		Onset and Death			
,	į	resulting in death) Sepsis					
	_ 1	DUE TO (OR AS A CONSEQUENCE OF):					
	RTIFICATION	Sequentially list conditions, Acquired Immune Deficiency Syndrome					
9	3	If any, leading to immediate cause. Enter UNDERLYING		į į			
		CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF):					
		resulting in death) LAST					
	ပ	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24s, WAS AN	AUTOPSV	24b. WERE AUTOPSY FINDINGS			
	MEDICAL	Chronic Renal Failure	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
		1 TYES 2	MINO	OF DEATH?			
	-	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN		1 TES 2 NO			
1	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)					
	is I	1 YES 2 NO 1 Sinpetiant 2 ER/Outpatiant 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)					
	E	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 26d. DE\$CRIBE HOW I	NJURY OCCUR	ED			
	À	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 28e. PLACE OF INJURY — At home, ferm, street, fectory, office 28f. LOCATION (Street					
	tural Route Number,						
i		4 Homicide datarmined					
	COMPLET	29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and main one.					
	5	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, an	d due to the ca	use(a) and manner as stated.			
29c. LICENSE NUMBER 29d. DATE SIGNED (Mc							
1	. 111	296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 297. LICENSE NUMBER	29d. DATE SIG	9 Dra -			

C/O Maryland

General Hospital

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

Serena Barakat M.D.

31. DATE FILED (Month, Day, Year)

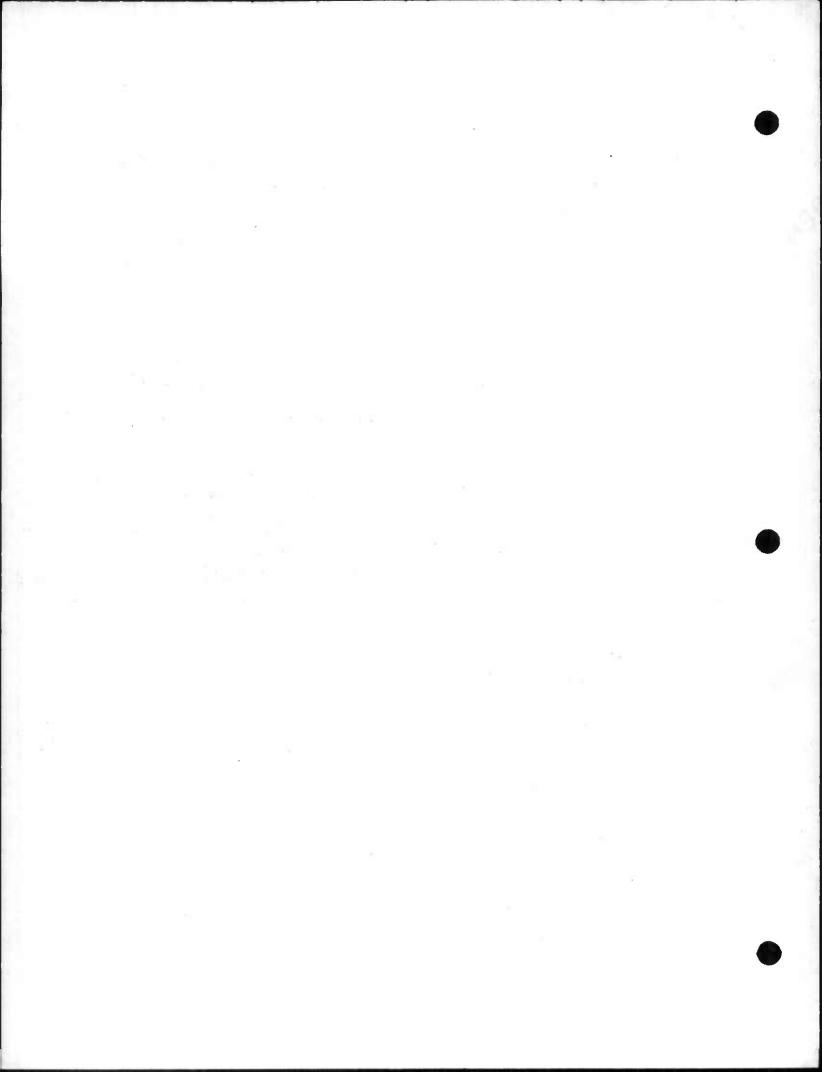
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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATN 3. TIME OF DEATN YEAR 9:00 A. William Hunter Tarr, Jr. July 6, 1995 4. SOCIAL SECURITY NUMBER 5 SEX 8. AGE (In yrs, lest birthday IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign 71 DAYS 1 X M 2 | F 216-12-3238 .1944 January 21 Maryland permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR 919 Adana Road Pikesville Baltimore RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Pikesville 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 919 Adana Road use as the burial-transit 21208 United States retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc. 1 YES 2 NO Specify: BΥ 3 Widowed 4 Divorced W. W. II Caucasian COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high page 5 should be detached for Elementary/Secondary (0-12) Collega (1-4 or 5+) B. X. Technician C. & P. Telephone Company 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) William Tarr, Sr. 16 Beatrice Mills BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 919 Adana Road Pikesville, MD 21208 Nancy Louise Tarr hours after death. Page 6 may be pe METHOD OF DISPOSITION

Burlel 2 Cremation 3 Re 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must DATE funeral director, Druid Ridge Cemetery July 10,1995 Pikesville, Maryland Donation 5 Other (Specify) examiner 21. SIGNATURE, OF FUNERAL SERVICE LICENSIEE 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, INC. filled in by the fillion, or removal. 8728 Liberty Rd.Randallstown, MD 21133-4784 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart fellure. List only one cause on each line. Interval Between cremation, or IMMEDIATE CAUSE (Final Onset and Death the disease or condition resulting in death) completely Menoma event, DUE TO (OR AS A CONSEQUENCE OF and con burial, c executed years traumatic CERTIFICATION Sequentially list conditions, 9 DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING attending physician pe prior certificate CAUSE (Disease or Injury other Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 signed by the atter Health and Mental Injury. PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. the MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? requires that any 1 TYES 2 NO shows a 1 YES 2 NO been to DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO NO PHYSICIAN: UNCERTAIN M Dept. WE 23 has 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL Hem State certificate HOSPITAL OTHER: OR ATTENDING PHYSICIAN: 1 YES 2 NO 1 [] Inpatient 2 [] ER/Outpatie 4 Nursing Nome 5 Residence 8 Other (Specify) 6 the 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED marked, With this 1 Natural 1 YES 2 NO BY After 2 Accident DIRECTOR: At hours after de item 28 is n 3 Suicide 26s. PLACE OF INJURY — At home, farm, street, tectory, office building, atc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) Could not be COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(e) and menner as stated. TO THE HOSPITAL OF TO THE FUNERAL D be filed within 72 ho MEDICAL EXAMINER: Or in and/or investigation, in my opinion, death occurred at the time. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 2 30, NAME AND ADDRESS OF PERSON KETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE FILED (Month, Dev.) A REGISTRAR SOIGNATURE



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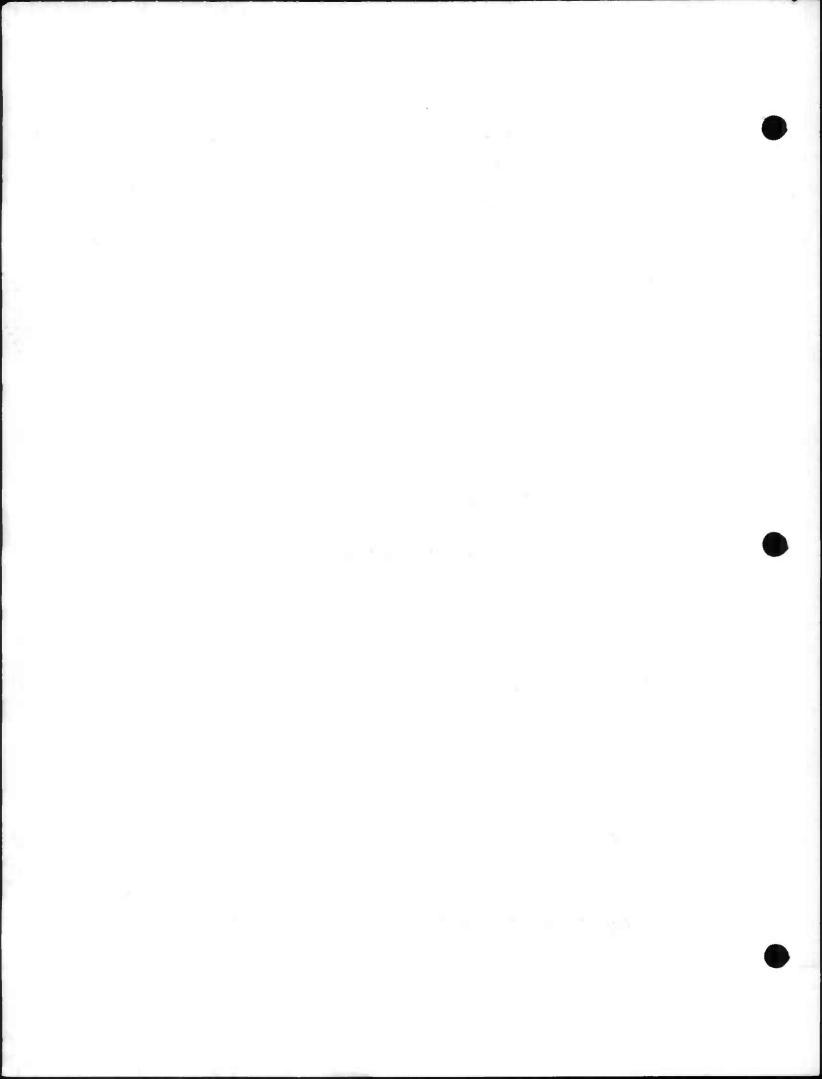
32. REGISTRAR'S SIGNATURE Studen Real

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH Webster 1995 Evelyn 2,10 July 4. SOCIAL SECURITY NUMBER 224-30-6830 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER t YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 - M 2 X F 25, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR NA RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN DR LOCATION 10d. INSIDE CITY Baltimore NA Ma 1 X YES 2 NO BE COMPLETED BY FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Longwood S U 4216 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 ND 11. MARITAL STATUS 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-if yes, specify Cuben, Mexicen, Puerto Rican, atc.) 14. RACE — American Indien, Black, White, atc. FORCES? 1 TYES 2
IF YES, GIVE WAR DR DATES 2 Merried 1 Never Married 1 TES 2 NO Specify 3 Wildowed 4 Divorced 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most ifle. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY lary/Secondary (0-12) College (1-4 or 5+1 5th grade NA Home. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, emue ORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Str 5 ě METHOD OF DISPOSITION 20e, METHOD OF DISPDSITION
1) Burlel 2 Cremetton 3 Removal from State
4 Donation 5 Other (Specify) 17/14/95 PLACE AND DATE OF DISPOSITION (Name of Hen Parki 21. SIGNATURE OF FUNERAL SERVICE LICENSEE AND ADDRESS OF FACILITY F.H. 2/2/1 els Wabash 4300 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximats shock, or heart fallure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Desth disease or condition erminal Cancer Lung resulting in death) DUE TO (DR AS A CONSEDUENCE DF): 5 days ehydration PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events OUE TO (OR AS A CONSEDUENCE OF): QUE TO (DR AS A CONSEDUENCE DE) resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY Uterine Cancer 1 YES 2 NO OF DEATH? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Inpatient 2 ER/Outpetlent 3 DOA OTHER: 1 YES 2 ND 4 - Nursing Ho ne 5 🗆 Residenca 8 🗆 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? TIME DE 28d. DESCRIBE HOW INJURY OCCURED 1 Netural BY 1 YES 2 ND 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide determined 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(a) and menner as attated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(s) and menner es stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

July 9, 1995 BE M.D. 041365 2 WICKS III M.D. 30. NAME AND ADDRESS OF PERSON

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should Pages 1, 2, 3 permit. burial-transit nospital or attending physician. be detached for use as the phods page 5 s director, funeral the filled in by cremation, and completely for burial, cremation prior to physician this certificate has been signed by the attending phy with the State Dept. of Health and Mental Hygiene HOSPITAL OR ATTENDING PHYSICIAN: The law requires that EUNERAL DIRECTOR: After this certificate has been signed by within 72 hours after death with the State Dept. of Health an

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10a. STATE

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) Helen WRIGHT 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS 214-40-5003 1 M 2 XX 97

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO

College (1-4 or 5+)

4

2. DATE OF DEATH July

3. TIME OF DEATH 2:00

1995 8. BIRTHPLACE (State or Foreign Maryland

7. DATE OF BIRTH
April 19, 1898 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH

15b. KIND OF BUSINESS/INDUSTRY

OATE 20c. LOCATION — City or Town, State

Rossville **BAltimore**

10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Middle River 1 TYES 2 X NO 10g. CITIZEN OF WHAT COUNTRY?

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-

If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES ZYNO Specify:

Baltimore 10f. ZIP CODE

Teacher

20b. PLACE AND DATE OF DISPOSITION (Name of

YRS.

21220

U.S.A. 14. RACE — American Indian, Black, White, atc.

Specify: White

Interval Between **Onset end Death**

24hours

IF YES, GIVE WAR OR DATES 3℃KWidowed 4 □ Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade complete

Se. FACILITY NAME (If not institution, give street and number)

2126 Oakland Road

RESIDENCE OF DECEDENT

1 Never Married 2 Married

Elementary/Secondary (0-12)

Maryland

11. MARITAL STATUS

10a. STREET AND NUMBER

Franklin Square Hospital Center

16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)

Baltimore City School

17. FATHER'S NAME (First, Middle, Last) Joseph Jeffers 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Wright

19a. INFORMANT'S NAME (Type/Print) Alice O.D. Smith

19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2126 Oakland Rd. Middle River, MD. 21220

20a. METHOD OF DISPOSITION (XDSurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIGHTIER

HOTTY HITT Mem. Gardens 7/10/1995 Baltimore, MD. 22. NAME AND ADDRESS OF FACILITY
Bruzdzinski Funeral Home P.A.

uh de 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such se cerdisc or respiratory errest, shock, or heart fellura. Use only one cause on each line. IMMEDIATE CAUSE (Finel

1407 Eastern Ave. Balt., MD.

Sequentielly list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury

disesse or condition

resulting in death)

1 🔯 Natural

2 Accident

3 Suicide

4 Homicide

DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):

Large Cerebral Infarct

DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 | YES 2 | NO

29d. DATE SIGNED (Month, Day, Year)

25. WAS CASE REFERRED TO MEDICAL 1 TES 2 NO 27. MANNER OF DEATH

5 Pending

S Could not be

26. PLACE OF DEATH (Check only one) OTHER: 4 Nursing Home 5 Residence 8 Other (Specify)

1 ☑ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT WORK? 26b. TIME OF INJURY

28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO 291. LOCATION (Street and Number or Rural Route Number, City or Town, State) 26e. PLACE OF INJURY — At home, farm, street, fectory, office building, stc. (Specify)

29a. CERTIFIER

1 🗵 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIES

200 LICENSE NUMBER

1061

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Muca

Rafae1 Perez-Mera, M.D. 404 Eastern Boulevard Baltimore, MD

32 REGISTRAR'S SIGNATURE 1 1 1985

24hours

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	
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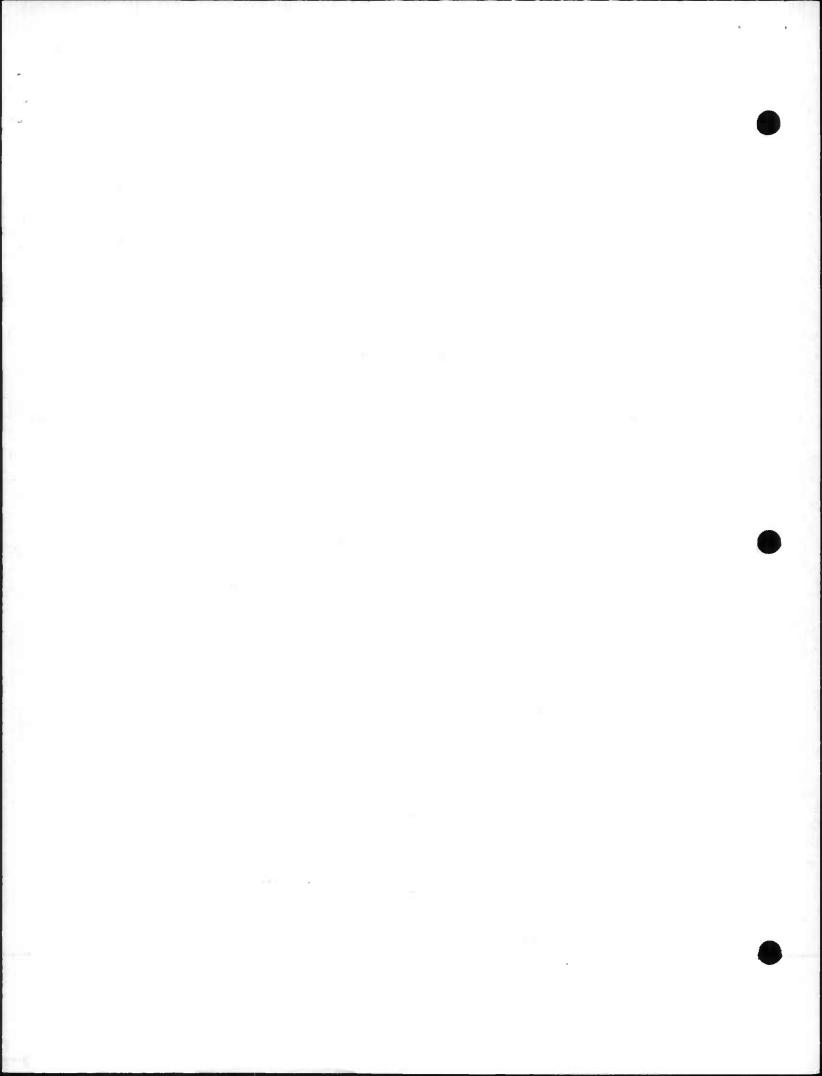
31. DATE FILED (Month, Day, Year)

JUL 1 1 1995

32 REGISTRAR'S NGNATURE

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Wilkes eman June 7:20 PMM 9 1995 0 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 6. BIRTHPLACE (State or Foreig. 217-14-9408 1 M 2 F actober 03, VIRGINIA 1920 use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Mercy Medical Center DIRECTOR Bathimore toc. CITY, TOWN OR LOCATION 10a. STATE 10d. INSIDE CITY LIMITS? M4 Baltimore 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Street 810 Light 21230 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yee, specify Cuben, Mexican, Puerio Rican, etc.)
1 YES 2 NO Specify: 1 X Never Married 2 Merried BΥ Specify: 3 Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) SYRUP FACTORY WORKER at once. 17. FATHER'S NAME (First Middle Last) JOHN Edward EE JACKSON FLORENCE BE notified 19. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or 2 8310 NUNLEY DR. KOBERT WILKES C Balto, Md. 21234 APT e a 20e. METHOD OF DISPOSITION

1 Description | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Meth 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must t filled in by the funeral director, MORELAND MEMORIAL PARK PARKVIlle ☐ Donetion 5 ☐ Other (Specify) examiner 22. NAME AND ADDRESS OF FACILITY 21. SIGNATURE OF FUNERAL SERVICE LICENSEE EVANS CHAPEL OF MEMORIES 8800 HARFORD Rd. Baltimore, Md 21234 event, the medical 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert failure. Lint only one ceuse on each line. Approximate cremation, or IMMEDIATE CAUSE (Finel Onset and Death Sophogeal Carer disease or condition resulting in death) completely DUE TO (OR AS A CONSEQUENCE OF) burial, traumatic and (CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): attending physician an ntal Hygiene prior to if eny, leading to immediate cause. Enter UNDERLYING other t CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST Mental } signed by the a Health and Men PART II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL any 1 TYES 2 NO OF DEATH? shows 1 YES 2 NO been f. of l PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES Dept. 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) State certificate **EXAMINER?** OTHER: 1 YES 2 NO npetient 2 - ER/Outpetient 3 - DOA 4 - Nursing Home 0 the 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) . this L 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked. 1 Natural 1 YES 2 NO DIRECTOR: After the hours after death v BY 2 Accident 26e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 90 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 28 4 Homicide item 29e. CERTIFIER 1 DERTIFYING PHYSICIAN: To the best of my knowledge, westh occurred at the time, THE HOSPITAL (THE FUNERAL D filed within 72 h (Check only one) = 2 MEDICAL EXAMINER: On the beele of exemination TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: 1 nd due to the cause(s) end manner ee stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Tone 29, 1995 2 1 82/tmore, MD 21228 VE KEEN VALKED DAVUE Charles J. Vana His-



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.	the function. Interview and the state Dept. of Head Hydrogen prior to build, creation of the control of the as the build-transit permit. Pages 1, 2, 3 should be fellected for use as the build-transit permit. Pages 1, 2, 3 should be fellected within 72 build and Member and Management of the control of the
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		1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ID / DEPARTMENT CERTIFICATE	OF HEALTH AND	MENTAL HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH	
		FRANK Edw	ard Wei	land, SF		JULY A	1995	10 15 P M	
			S. SEX 6. AGE (In)	rs. last birthday) IF UNDER	YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	8,8	IRTHPLACE (State or Foreign	
		219-01-3460	XM2 0 F 74	YRS. MONTHS	DAYS HOURS MIN.	Nov 10,	920 N	ountry)	
		9e. FACILITY NAME (If not institution, give street	t and number)	9b. CITY,	TOWN OR LOCATION OF I		9c. COUNTY	OF DEATH	
	E C	2218 WESTR	DGE Rd.	-	TIMONIT	104		-TIMATE	
	CTOR	RESIDENCE OF DECEDENT	DOIL TO			0147	-	-1 IIVIal E	
	DIREC	10a. STATE 10b. COUNTY	4	toc. CITY, TOWN O				10d. INSIDE CITY LIMITS?	
			imor	Time	MIUM			1 TES 2 NO	
	FUNERAL	10a. STREET AND NUMBER	. D 1		10f. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?	
	ÿ	2218 WESTRI	DEE KA		2109	3	0	SA	
	ᆵ	11. MARITAL STATUS 1 Never Merried 2 Merried	2. WAS DECEDENT EVER IN U. FORCES? 1 YES		AS DECENDENT OF HISP/ yes, specify Cuben, Maxic	ANIC ORIGIN? (Specify Ye	or No — 14, F	RACE — American Indian, Black, White, atc.	
	BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATE		YES 2 NO Spec			Specify:	
			WWI					WHITE	
	1	16. DECEDENT'S EDUCA: (Specify only highest grade co	mpleted)	Ba. DECEDENT'S USUAL OC (Give kind of work done d life. Do NOT use retired.)		18b. KIND OF BU	SINESS/INDUSTR	RA	
	اي	Elementary/Secondary (0-12)	College (1-4 or 5+)			Const	RUCTIO	4.1	
eg.	COMPLETED	AT SATURDIO MANOS (ST. AMAGE)		MASON				7	
9		17. FATHER'S NAME (First, Middle, Last)	1		18. MOTHER'S N	AME (First, Middle, Melden	Sumame)		
P 9	BE		and	,	Gert	rude Vo		rdon	
F .	2	19a. INFORMANT'S NAME (Type/Print)			(Street and Number or Rura				
9			lland	2218 Wes	TRIDGE RO	1. Timoniu	m Mld.	21093	
nst		20a METHOD OF DISPOSITION 1 M Burlel 2 Cremetion 3 Remove	20b. PL cemeter	ACE AND DATE OF DISPOSITY, crematory or other place)	TION (Name of	DATE 20c. LO	CATION - City of	or Town, State	
E		4 Donation 5 Other (Specify)	Du	LANEY Valley			MONIU	M.Md	
틢		21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE		AME AND ADDRESS OF F				
exa		Charles &	1 / Vans h	. 5	1ANS Chape 325 YORK	ed Time	es N	Nd. 21093	
100		23. PART i. Enter the diseases, or con	nplications that caused th			ch as cardiac or read	retory arrest	Approximate	
the medical examiner must be notified at once.		anock, or heart failure. Lis	t only one cause on each	ine.	,,,		natory arreat,	Interval Batween	
#		iMMEDIATE CAUSE (Final disease or condition	[00148d	1	DISEASE			Onset and Death	
ent,		resulting in death) a	DUE TO (OR AS A CO	ARTERY	DISTASE				
2	_		CONGESTIVE		FAILURE			i	
mat	<u>ō</u>	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CO	0 10 - 111	Allone				
E .	¥	cause. Enter UNDERLYING		and possession.					
he	Ĕ	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CO	ONSEQUENCE OF):					
2	CERTIFICATION	resulting in death) LAST							
injury, or other traumatic event,	2	0.							
	AL	PART ii. Other algnificant conditions of	contributing to death but	not reaulting in the unc	lerlying cause given in	Part i. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
shows any	EDIC	COPD			···	1 □ YES 2		COMPLETION OF CAUSE OF DEATH?	
OWS	ME	HYPERTENSION					7	1 TYES 2 NO	
3 sh		DID TOBACCO USE CONTRIE	BUTE TO CAUSE OF I	DEATH YES N	O UNCERTAL	N 🗆			
m 23	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		PLACE OF DEATH (Check of	nly one)				
r Item	Sign		IOSPITAL: Inpetient 2 ER/Outpetie	ort 3 DOA 4 Numb	ng Home 5 🗆 Rasidence	B □ Other (Specify)			
d, 0r	Ξ	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME OF	28c. INJURY AT	28d. DESCRIBE HOW I	NJURY OCCURE	0	
marked,	7	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY M	WORK? 1 YES 2 NO				
	BY	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY —	At home, term, street, facto	ry, office	281. LOCATION (Street a	and Number or Ru	rel Route Number	
23		4 Homicide determined	building, etc. (Specify)			City or Town, State)			
8	D- 25		M. T. M. A. A. A. A. A. A. A. A. A. A. A. A. A.						
9	9	29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and menner as stated.							
If Item	MPLET	(Check only 1 CERTIFYING PHYSICIA		elles leurettes le		e time, data and place, an	d due to the cau		
ANT: If Her	COMPLET	(Check only one) 2 MEDICAL EXAMINER	On the beals of examination an	ed/or investigation, in my op	inion, death occured at the			se(s) and menner as stated.	
PORTANT: If Her	COM	(Check only 1 CERTIFYING PHYSICIA		ed/or investigation, in my op	29c. LICENSE NU		29d. DATE SIGN	NED (Month, Day, Year)	
IMPORTANT: If Iter	BE COM	(Check only 2 MEDICAL EXAMINER OF CERTIFIER	on the beals of examination and				29d. DATE SIGN		
IMPORTANT: If Iter	COM	(Check only 2 MEDICAL EXAMINER OF CERTIFIER 296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO C	On the beals of examination and the beals of examination and the beals of the beals of the beat here.	(ITEM 27) (Type, Print)	29c. LICENSE NU	MBER	≥ JUL	NED (Morith, Day, Year) _Y 6, 1995	
IMPORTANT: If Iter	BE COM	(Check only 1 b) CERTIFTING PHYSICIA (Check only 2 MEDICAL EXAMINER CO. 29b. SIGNATURE AND TITLE OF CERTIFIER 20. NAME AND ADDRESS OF PERSON (1910) CO. NAME ADDRESS OF PERSON (1910) CO. NAME AND ADDRESS OF PERSON (1910) CO. NAME AND ADDRESS OF PERSON (1910) CO. NAME AND ADDRESS OF PERSON (1910) CO. NAME AND ADDRESS OF PERSON (1910) CO. NAME AND ADDRESS OF PERSON (1910) CO. NAME AND ADDRESS OF PERSON (1910) CO	Ne mal Mo	(ITEM 27) (Type, Print) 2 G	29c. LICENSE NU	MBER	≥ JUL	NED (Morith, Day, Year) -Y 6, 1995	
IMPORTANT: If Iter	BE COM	(Check only 2 MEDICAL EXAMINER OF CERTIFIER 296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO C	On the beals of examination and the beals of examination and the beals of the beals of the beat here.	(ITEM 27) (Type, Print) 2 G	29c. LICENSE NU	MBER	≥ JUL	NED (Morith, Day, Year) _Y 6, 1995	

CIP

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing a figure death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR	OTALE OF IN	CE				DEATH	MITIAL	REG. NO.	_		
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH									3. TIME OF DEATH		
	THOMAS	THOMAS		WOLFSON			JU	MONTH DAY YEAR			12:36 P M	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER 1		IF UNDER 24 HRS.	7. DAT	E OF BIRTH		8. BIRTHE	PLACE (State or Foreign
	133-16-6980	1 X M 2 D F	69	YRS.	MONTHS	DAYS	HOURS MIN.	JÜ	Y 7,19	25	EAS	T GERMANY
	9a. FACILITY NAME (If not institution, give str	est and number)			9b. CITY, T	OWH OR	LOCATION OF D			_	NTY OF DE	ATH
DIRECTOR	5715 PARK HEIGH	ITS AVEN	NUE	BALTIMORE						N/A		
H	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWH OR	LOCATIO	ON					10d. INSIDE CITY LIMITS?
		N/A			BA	LTIM	ORE					1 XYES 2 NO
FUNERAL	100. STREET AND NUMBER 5715 PARK HEIGHTS	AVE., AP	т. 409			101. 2	ZIP CODE	212	15	10g. CITI	ZEN OF W	HAT COUNTRY?
	11. MARITAL STATUS 1 Never Married 2 Married	XYES 2 N	ER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIO (ES 2 NO If yes, specify Cuben, Mexican, Puerl			NIC ORIG	ORIGIN? (Specify Yes or No. 14. RACE -			- American Indian, White, etc.		
BY	3 Widowed 4 Divorced	IF YES, GIVE WA		1 OR DATES 1 TYES 2 NO Specify			ly:			Specify		
	15. DECEDENT'S EDUC		KOREAN 16a, DEG	EDENT'S	USUAL OCC	UPATION		16	b. KIND OF BUS	INESS/IND	USTRY	WHITE
	(Specify only highest grade (Elementary/Secondary (0-12)	College (1-4 or 5+)	(Gh	re kind of v Do NOT us	vork done dur	ing most	of working					
COMPLETED	12			AILR	MOC	CLE	RK		SOCIA	L SE	CURIT	Y
	17. FATHER'S NAME (First, Middle, Last) JULIUS J.	WOLF	SON				18. MOTHER'S NA		Middle, Maiden			
BE	19s. INFORMANT'S NAME (Type/Print)		100	MAN INC	ADDRESS (CHARLO			KUHI		
임	MR. ROBERT R. WOLI	PSON					Number or Aural					
	76. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remo		20b. PLACE A								City or Tow	un Ptoto
	1 Buriel 2 Cremation 3 Remo	val from State	cemetery crem	RYLA	ND VE	TERA	NS 7-	1	95 OWI			
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE					ADDRESS OF FA	CILITY	00S T	NIC		
	> allengue	. NUM	no!	00							TMORE	E, MD 21215
	23. PART I. Entar tha diaeases, or co	mplications that	caused the dea	ith. Do n								Approximata
	shock, or heart fellure. L	ist only one caus	e on aach line.							•		Interval Between Onset and Death
	disease or condition	Arterio	oscler	otic	Car	dio	vascul	ar	Diseas	se		
1			OR AS A CONSEO									
N	Sequentially list conditions,											
CERTIFICATION	if any, leading to immediata cause. Enter UNDERLYING	DUE TO (C	OR AS A CONSEQ	UENCE OF	7);							
FIC	CAUSE (Disease or Injury that initiated events	DUE TO ((OR AS A CONSEC	UENCE OF	n:							
E	resulting in death) LAST											
- 11	DATE (1 ON 1 144 1		sath but not resulting in the underlying cause given in Part I.									
DICAL	A CONTRACTOR OF THE CONTRACTOR			aulting i	n tha unda	irlying o	cause givan in	Part I.	24s. WAS AN / PERFORI			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
EDIC	CARGNOMA OF LUNG							1 YES 2X NO			COMPLETION OF CAUSE OF DEATH?	
Σ	DID TODA 600 HOT 601 HT								TUSPE	TOUN		1 TYES 2 NO
AN	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL	IBUIE 10 CAU			H (Check only		UNCERTAI	и Ц				
PHYSICIAN:	EXAMINER?	HOSPITAL:		T	OTHER:							
Ĭ	27. MANNER OF DEATH	28a. DATE OF II		28b. TIME		g Home	5 X Residence		er (Specify) SCRIBE HOW IN	HIBY OCC	TIPED	
ВУ Р	1 Natural 5 Pending	(Month, Day,	(, Ybar)	INJ	JRY	WORK	(? S 2 □ NO		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	50111 000	ONED	
	3 Suicide 8 Could not be	28e. PLACE OF	INJURY — At hora	10, term, s	treet, factory	, office			CATION (Street ar	nd Number	or Rural Ro	ute Number,
COMPLETED	4 Homicide determined		ia (opoony)					City	or Town, State)			
7	29a. CERTIFIER (Check only 1 CERTIFYING PHYSIC	IAN: To the best of m	ny knowledge, des	th occurre	d at the time	, data an	nd place, and due	to the co	use(s) and man	ner as state	ed.	
one) 2 X MEDICAL EXAMINEF: On the besis of examination and/or investigation, in my opinion, death occurred at							th occured at the	time, dat	e and place, and	due to the	cause(s)	and manner as stated.
BE C	29b. SCHATURE AND TITLE OF CERTIFIER	Vn				2	9c. LICENSE NUN	MBER		29d. DATE	SIGNED (Month, Day, Year)
10	Melynte hel	Trill					O.C.M	1.E.		▶JU	LY 5	1995
	30. NAME AND APPRESS OF PERSON WHO								Late 16		J = - 1	21203
	Margarita Kore			Pen	n St	ree	τ, Bal	LTIN	ore, l	Mary	Tanc	1 21201
	JUL 1 1 1995	32. REGISTRAR	or hardall									
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

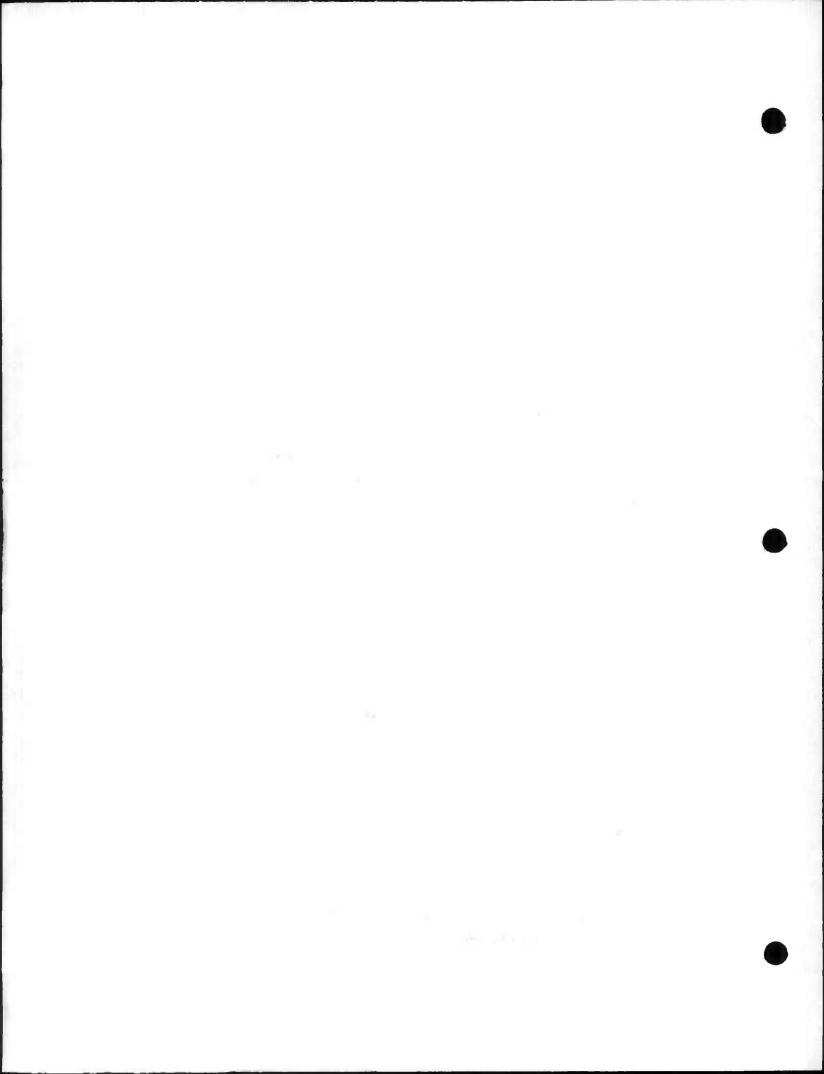
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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH 3. TIME OF DEATN 1995 July Freida Mae Whetsell 8:59 p 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTN (Month, Day, Year) June 18 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTNPLACE (State or Foreign DAYS 69 YRS. 1 M 2 X F 407-22-1369 Kentucky 26 use as the burial-transit permit. Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Johns Hopkins Bayview Baltimore NA 10c. CITY, TOWN OR LOCATION 10a, STATE 10d. INSIDE CITY LIMITS? Maryland NA Baltimore 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Broening Hwy. 1108 21224 U.S.A. retained by the hospital or attending physician. 5 should be detached for use as the burial-tran-11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Rican, atc.) Specify: 1 TES 2 NO BY Specify: White 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 12 NA Home Maker Own Home 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) at a Caudil1 Paris Fletcher June BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Robert Whetsell Jr. Gill St. 1295 Odenton, MD. 21113 hours after death. Page 6 may be pe 20a. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State the medical examiner must X□ Burial 2 □ Cremation 3 □ Ra funeral director, Sacred Heart of Desus July 12 Dundalk, MD. 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE W. Dabrowski/Chojnacki F.H. P.A. 1005 Dundalk Ave. Balto. MD. 21224 Jan completely filled in by the rial, cremation, or removal. 23. PART I. Enter the diseases, or complicat ions mat caused the deeth. Do not enter tha mode of dying, such as cardiec or respiratory arrest, shock, or heart fallure. List only one cause on each line. signed by the attending physician and completely filled in Health and Mental Hygiene prior to burial, cremation, or i Interval Batween IMMEDIATE CAUSE (Final **Onset and Death** disease or condition resulting in death) Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): executed within event, years artery disease Moranary traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING 2 death certificate CAUSE (Disease or Injury other OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 6 Injury, PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. the MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? requires that Chromic obstructive pulmonary disease shows any 1 YES 2 NO 1 YES 2 NO t. of ! DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. WE 23 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law TO THE FUNERAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dep IMPORTANT: If Item 28 is marked, or Item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TES 2 NO Inputient 2 X ER/Outputient 3 DOA 4 Nursing Nome 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident 5 Pending 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 8 Could not be 4 Homicide determined 29s. CERTIFIER
(Check only one)

2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated, one) 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE Kodney Broo D 43636 Ks ▶July 10, 1995 he 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Witzke Center 3411 Bank St. Balto., M.D. Rodney Brooks M.D. 31. DATE FILEO (Month, Day, Year)

JUL 11 1995 32 DEGISTRAR'S GNATURE



BALTIMORE, MARYLAND 21215-0020	Hours after death. Page 6 may be retained by the hospital or attending physician.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within z

		1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPART	MENT OF HEALTH AND	MENTAL HYGIENE REG. NO.					
_		1. DECEDENT'S MAME (First, Middle, Last)	NOREWS.		2. DATE OF DEATH MONTH 07 DAY 07 95 12:30 P M					
		1)117 11/ 6101		IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Joan) 1933	BIRTHPLACE (State or Foreign Country)				
2, 3 should	стоя	90. FACILITY NAME (If not institution, give stre	of and number)	96. CIEV-TOWN OR LOCATION OF D	EATH 9c. COUNT	Y OF DEATH				
Pages 1, 2	W	10a. STATE 10b. COUNTY	A/A 10c. CITY,	TOWN OF LOCATION		10d. INSIDE CITY LIMITS?				
permit.	RAL DI	190. STREET AND NUMBER	tin Ct	101. ZIP CODE	10g. CITIZE	1 ☐ YES 2 ☐ NO				
burial-transit	FUNER	11. MARITAL STATUS 1 Never Married 2 W Married	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO	13. WAS DECENDENT OF NISPAL If yes, specify Cyrosn, Maxico		4. RACE — American Indian, Black, Whits, atc.				
as the	ED BY	3 Wildowed 4 Divorced 15. DECEDENT'S EDUCA	IF YES, GIVE WAR OR DATES STION 168. DECEDENT'S U	1 TES 2 NO Specil	у:	Specify: Black				
ed for use	LET	(Specify only highest grade oc Elementary/Secondary (0-12)		ork done during most of working	166. KIND OF BUSINESS/INDU	on n p r <				
be detached at once.	E COMP	17. FATNISR'S NAME (First, Middle, Lijst)	Irous	18. MOTNER'S NA	ME (First, Middle, Malden Syrname)	MAN				
page 5 should be notified	TO BE	198 INFORMANT'S NAME (TOPPONT)	19b. MAILING A	AGDRESS (Street and Number or Rural	Route Number, City or Yawn, State, Zio C	ode) / 2 / 2 / /				
page 4		20s. METHOD OF DISPOSITION 1 W Burist 2 Cremation 3 Remove 4 Donation 6 Other (Specify)	206 PLACE AND DATE OF	SISPOSITION (Name of early lace)	DATE 20c. LOCATION - CH	ty or Town, State				
the funeral director, oval.		21. SIGNATURE OF FUNERAL SERVICE LICE	ISEE P D 111	22. NAME AND ADDRESS OF PA	USS Funer	al Home				
d in by the f or removal. medical ex	Н	23. PART I. Enter the diseases, or co	mplications that caused the deeth. Do no st only one cause on each line.	t enter tha mode of dying, auc	h as cerdiec or respiratory arres					
tion.		iMMEDIATE CAUSE (Finel disease or condition resulting in death)	1	R: non 6	mall cre	Interval Between Onset and Death				
nd completely burial, crema atic event,	N.	Sequentially list conditions.	Metastases	to liver.	mall cre					
hysician and c e prior to buria er traumatic	ICATIC	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury								
tal Hygiene p	CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):							
y and	AL.	PART II. Other algnificent conditions	contributing to death but not resulting in	the underlying ceuse given in	PERFORMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE				
this certificate has been signed b with the State Dept. of Health ar rked, or Item 23 shows any	: MEDIC	DID TORACCO LISE CONTRI	BUTE TO CAUSE OF DEATH YES	□ NO □ UNCERTAII	1 TYES 2 7 NO	OF DEATH?				
cate has t State Dept Item 23	SICIAN:	25. WAS CASE REFERRED TO MEDICAL	26, PLACE OF DEATH		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \					
the St	HYSI			I ☐ Nursing Home 5 ☑ Residence						
fter this eath with marked	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) INJUE	M 1 YES 2 NO	26d. DESCRIBE HOW INJURY OCCU	RED				
RECTOR: A rs after d m 28 is	ETED	3 Suicide 8 Could not be 4 Homicide detarmined 28e. PLACE OF INJURY — At home, farm, street, factory, offics building, stc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, offics City or Town, State)								
E FUNERAL DIRECTOR: Atter the within 72 hours after death watten 72 is mark	P		AN: To the best of my knowledge, death occurred On the basis of examination and/or investigation,							
TO THE FUNERA De filed within 7 IMPORTANT: I) BE	SHOW THE AND THE CERTIFIER	ND.	D 316	1860 29d. DATE S	SIGNED (Month, Day, Year).				
	(TO	30 MAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH (ITEM 27) (1700 P	GREENE	ST. BAUTO	o, ND.				
		JUL 1 2 1995	32. EGISTRAN'S SPIATURE			1				

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNENAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

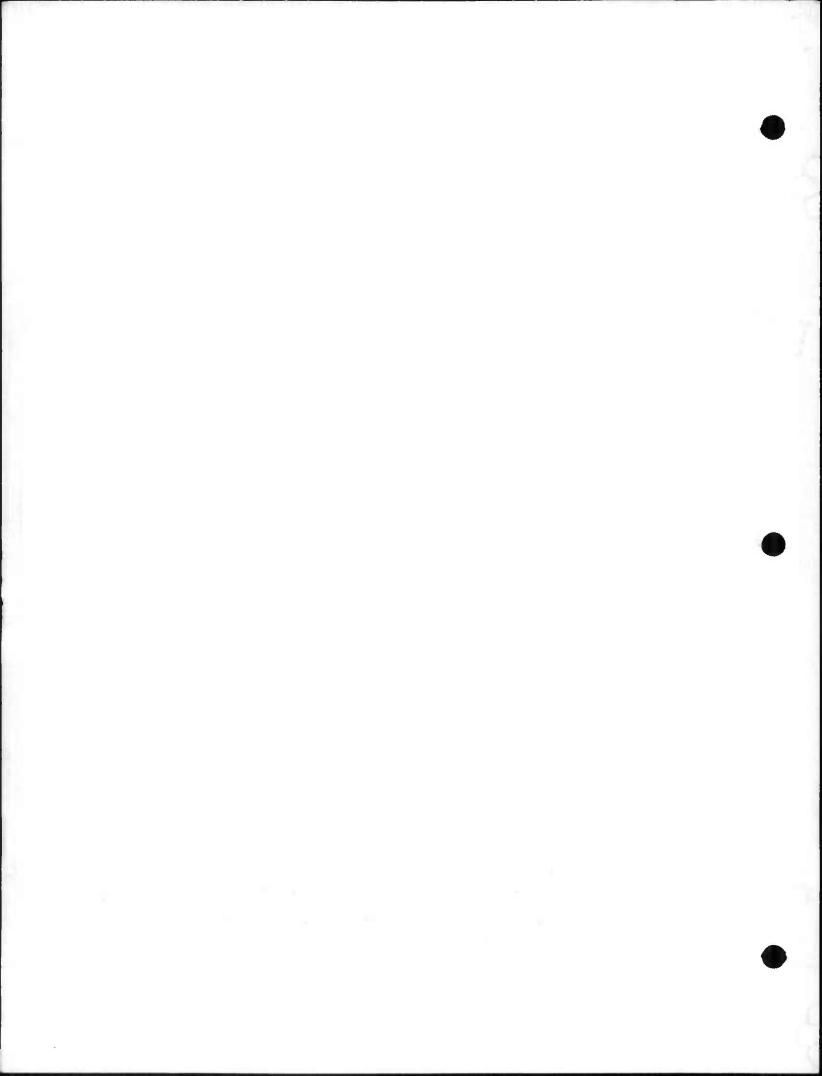
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MA	R	Y.	يا	4

	REGISTRAR		CE	RTIF	ICATE OF	DEATH		REG. NO.					
- 1	1. DECEDENT'S NAME (First, Middle, Linst) ELIZABETH	BROC	KINGTO	Me			2. DATE O MONTH	F DEATH DAY	100		TIME OF OEAT	H AM	
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. leas birthday) F UNDER 1 YEAR F UNDER 1 YEAR F UNDER 24 HMS. 7. DATE OF BIRTH (Month, Day, Mer.) A PR II 1917 VIR												
TOR	96. FACILITY NAME (If not institution, give strict and number) ST. AGNES HOSPITAL BALTIMORE N/A BESIDENCE OF DECEDENT												
DIRECTOR	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 14 MARYLAND N/A BALTIMORE 12											NO	
FUNERAL	100. STREET AND NUMBER BRIGHTON MANOR NURSING HOME 1501 DUKELAND ST. 21216 U.S. OF A 11. MARITAL STATUS 12. WAS DECEMBENT OF MURSING PROPERTY OF MURSING COLUMN FOR A LABORATORY OF MURSING												
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced FORCES? 1 YES 2 NO If YES, GIVE WAR OR DATES FORCES? 1 YES 2 NO If YES, GIVE WAR OR DATES FORCES? 1 YES 2 NO If YES, GIVE WAR OR DATES 13. Wes, specify Cuban, Maxican, Puerto Rican, stc.) 14. RACE — All Hack —										rita, atc.	n,	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5+)	(Give	a kind of w Do NOT us		oN st of working	16b. F	LAUN	NESS/INDUSTR	Υ			
BE COM	17. FATHER'S NAME (First, Middle, Lest) RICHARD BARNES		LIAUI	NDKI	200	ts. MOTHER'S NA ELIZAI		ddle, Maiden S	iumame)				
TO B	190. INFORMANT'S NAME (Type/Print) MRS. EVANGELINE		19b. 1	MAILING 347	ADDRESS (Street a PENTRI	nd Number or Runal I DGE RD	Route Number	TO.,	State, Zip Gode	.239			
	20a METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Remo 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE		ARBUTI	JS P		RK 7/13			ATION — CIFY O				
	· Lewis	- Sew	ynn	VYNN	LEWIS 4517	Z T. GV PARK HI	VYNN EIGHT	S AV	E. BAI			5	
	23. PART I. Enter the diseasea, or crahock, or heart fellure. L. IMMEDIATE CAUSE (Final disease or condition resulting in death)	iet only one call	ikalion	. Pn	ennem		h aa cerdia	or reapin	ntory arrest,		Approxima interval Be Onset and 3 multi-	tween	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
MEDICAL	Vulnuonary TB PERFORMED? 1 VES 2 NO OF										RE AUTOPSY FIN ILABLE PRIOR T IPLETION DF CA DEATH?	TO AUSE	
PHYSICIAN:	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			S NO CHECK only one)	UNCERTAIN	1 <u>2</u>						
	1 YES 2 NO 27. MANNER OF DEATH 1 Notural 5 Pending			28b. TIME	4 Nursing Home E OF 28c, INJI URY WO	RK?			JURY OCCURED)			
TED BY	Accident Investigation Investigation												
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC 2 MEDICAL EXAMINER									e(a) and	manner ee str	atea.	
TO BE CO	2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(a) and 29b. SIGNATURE AND TITLE OF CERTIFIER 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. OATE SIGNED (Mo. D. JUL 10)										oth, Day, Year)	_	
-	30. NAME AND ADDRESS OF PERSON WHO ICHN MACURE U, De	Ar. Madien	ie, 84.1.	ene	prim)) Hospita	1,900 Ca	ton A	e, Ba	ltimore	N	फ 212°	29	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR	'S SIGNATURE		7								

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	1 - STATE REGISTRAR		STATE OF N	MARYLA	ND / DEPA CERTIF					MENTAI	REG. NO.	E		
	1. DECEDENT'S NAME (First, M Margaret	C.		one						2. DATE MONTH		1995	EAR	:14 P
	4. SOCIAL SECURITY NUMBER 213-52-355	56	5. SEX	6. AGE (III	n yrs. lest birthday) YRS.	IF UNDER	1 YEAR DAYS	HOURS	MIN.		DE BIRTH Day, Year) — 4.7		Country)	ACE (State or Foreign
5	96. FACILITY NAME (If not institution of the instit	noria		ital				MOLE		ATH		9c. COUNT NOT	Y OF DEA	
DIRECTOR	Maryland		ry, тоwn c alti								Od. INSIDE CITY LIMITS? VES 2 NO			
FUNERAL	10s. STREET AND NUMBER			10	f. ZIP CODE		10g. CITIZEN OF WHAT COUNT							
	3509 Alamed 11. MARITAL STATUS 1 Never Married & XXM 3 Widowed 4 Divorce	arried	TCLE 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 24 NO IF YES, GIVE WAR OR DATES 13. WAS DECEMDENT OF HISPANIC ORIGIN If yes, specify Cuben, Mexican, Puerto F						IGIN7 (Specify Yea or No— 14. RACE— to Rican, etc.) 14. RACE— Black, Specify:			- American Indian, White, etc. Black		
COMPLETED	15. DECEDENT'S EDUCATION (Speecify only highest grade completed) Elementary/Secondery (0-12) 12 15. DECEDENT'S EDUCATION (Give kind of work done during most of working life. Do NOT use refired.) Manager Cust. Service Fox Chevrolet													
	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Norene Ann Newton													
2	RAVON THOMAS BOONE SI. 5309 Alameda Circle Balto., Md. 21216													
	20b. PLACE AND DATE OF DISPOSITION 1 Burial 2X Cremation 3 Removal from State A Donation 6 Other (Specify) The sign at the part of the specify of the specific o													
	22. NAME AND ADDRESS OF FACILITY Derrick C. Jones Funeral Home 4611 O Park Heights Ave. 23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate													
CEMIIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list condition if any, leading to immedia cause. Enter UNDERLYIN CAUSE (Disease or Injury that initiated events resulting in death) LAST	a.	Massiv	Je P (OR AS A Jeno (OR AS A	ch line.	ry E ombo	mbc	olus						Interval Betwee Onset and Dear Second:
PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Carcinoma of the Rectum Diabetes Mellitus 24a. WAS AN AUTOPSY PREFORMED? 1 Yes 2 No 24b. WERE AUTOPSY FINITY AMALAGE PHOR TO COMPLETION OF CALCULATION OF CALCULATION OF CALCULATION OF CALCULATION OF CALCULATION OF CALCULATION OF CALCULATION OF CALCULATION OF DEATH? 1 M YES 2 No											MAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?			
SICIAN	25. WAS CASE REFERRED TO I	1	IOSPITAL:	7		OTHER	1:	LACE OF DE	26				<u></u>	
	27. MANNER OF DEATH 1 Netural 5 Pe	YES 2 NO 1 Inpetient 2 KER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ER OF DEATH Sea. DATE OF INJURY (Month, Day, Year) DOA Sea. DATE OF INJURY (Month, Day, Year) NURY (M												
	3 Suicide 6 Co	Suicide 6 Could not be 266. PLACE OF INJURY — At home, farm, street, factory, office 261. LOCATION (Street and Number or Flural Route Number, buildings of control of the country of the c									ite Number,			
COMPLE			AN: To the best of On the basis of s											nd manner as stated.
	29b, SIGNO WE AND TITLE O		Ow, of 1	2. (essec.	Part	% .	29c. LUCEI	SE NUM	BER OS		29d. DATE S	IGNED (A	forth, Day, Your) 7, 1995
2	30. HAME AND ADDRESS OF P	ERSON WITO	COMPLETED CAUS	OF DEA	TH (ITEM 27) (Typ	July Vul	ERS	iry .	RA	KWH	0 (3	all in	088	1, 1995 -21208
	31. DATE FILED (Month, Day You 1995)	15 Jul	120 ES 124	gs flav	Nest.									



BALTIMORE, MARYLAND 21215-0020

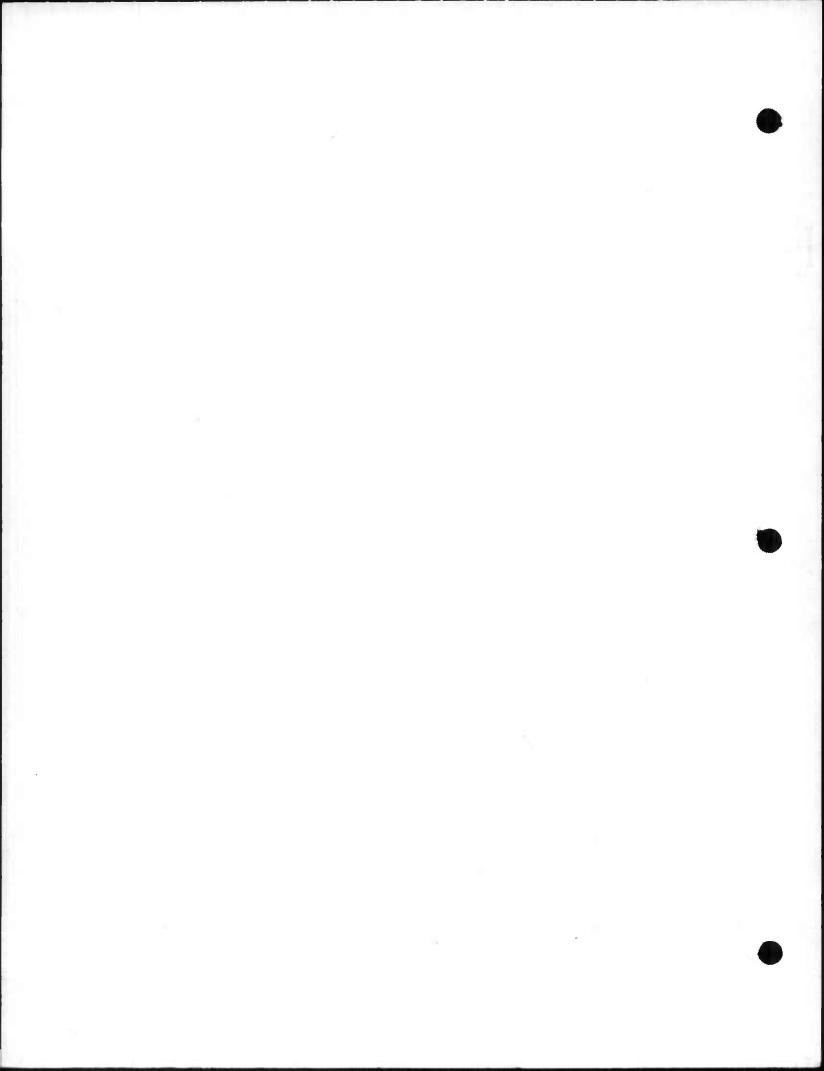
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL HYGIENE
CERTIFICATE OF DEATH	REG NO

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR CERTIFI	MENT OF H	EALTH AND I	MENTAL HYGIEN		20017			
	1. DECEDENT'S NAME (First, Middle, Last) SYLVIA CHRISTI	NE	BULLC			2. DATE OF DEATH					
-	-11	1 M 2 DF 5	yrs. lest birthday)	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 3-1-1938	6. Bil	RTHPLACE (State or Foreign unitry) N, C,			
TOR	90. FACILITY NAME (If not institution, give sti GREATER BALTIMORE RESIDENCE OF DECEDENT		ER	TOWSO	R LOCATION OF DE	АТН	9c. COUNTY O				
DIRECTOR		NA		TOWN OR LOCAT	ON			10d. INSIDE CITY LIMITS? 1 PYES 2 NO			
FUNERAL	100. STREET AND NUMBER GREENSPRING 11. MARITAL STATUS	A VE 12. WAS DECEDENT EVER IN U			ZIP CODE 2/2//		US				
B	II i N Lianai mattian 7 i Mattiad	FORCES? 1 YES	2 NO	If yes, spe	ENDENT OF HISPAN ecity Cuben, Mexices 2 NO Specify	IIC ORIGIN? (Specify Yeen, Puerto Ricen, etc.)	В	ACE — American Indian, lack, White, etc. pecify: BLACK			
LETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5 +)	life. Do NOT use	ork done during mos retired.)	t of working	16b. KIND OF BUS					
COMPL	17. FATHER'S NAME (First, Middle, Last)		TELEPH	DNE C	-	ME (First, Middle, Meiden					
examiner must be notified at once. TO BE COM	MOSES BULLO 19a. INFORMANT'S NAME (Type/Print)	CKI	19b. MAILING	ADDRESS (Street of	BETTY and Number or Ryfall R	PLUM A Number, City or Town	NER_ n, State, Zip Code)				
5 F	Hugustus 200. METHOD OF DISPOSITION	Bullock	3911		idge F	D BALT M	D 21	229			
must	1 @ Suriel 2 Cremation 3 Removal from State 4 Donation 5 Dither (Specify)										
amine	21. SIGNATURE OF FUNERAL SERVICE LICE	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF ACILITY BETTS FUNERAL HOME									
	23. PART I. Enter the diseases, or complicatione that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate										
event, the medical	IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. LUNG CANCER										
	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
y, or other traumatic CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):										
를 실	PART II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS										
red, or item 23 shows any PHYSICIAN: MEDIC.		CHRONIC OBSTRUCTIVE PULMONARY DISCHOOT 1 YES 2 BIND AMALABLE PRIOR TO COMPLETION OF CAUSE OF OPERATOR 1 YES 2 BIND 1 YES 2 BIND									
M Z3	25. WAS CASE REFERRED TO MEDICAL										
or item	1 YES 2 NO	PIOSPITAL: 1 Appatient 2 ER/Outpatie	ent 3 DOA		5 Residence	B C Other (Specify)					
marked, BY PH	27. MANNER OF DEATH 1 Natural 5 Pending Investigation	28e. DATE OF INJURY (Month, Day, Year)	285. TIME INJU	RY WOF	RY AT IK? ES 2 NO	28d. DESCRIBE HOW IN	IJURY OCCUREO				
TED 28	Accident investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — building, etc. (Specify)	At home, ferm, str	reet, fectory, office		281, LOCATION (Street e. City or Town, Stete)	nd Number or Run	ni Route Number,			
D BE COMPLETED		IAN: To the best of my knowled : On the beele of examination e						e(e) end manner se stated.			
TO BE	294 SIGNATURE AND TITLE OF CERTIFIER	V amo	s pur		29c. LICENSE NUM D387	50 BER	29d. DATE SIGN	7/95			
	30. NAME AND ADDRESS OF PERSON WHO MANUEL PAR			2/L F	D, BA	CTIMORE	3 MO	21212			
1	"JUL" 2"1995" Jahr	Charles Anstrong	VRE								



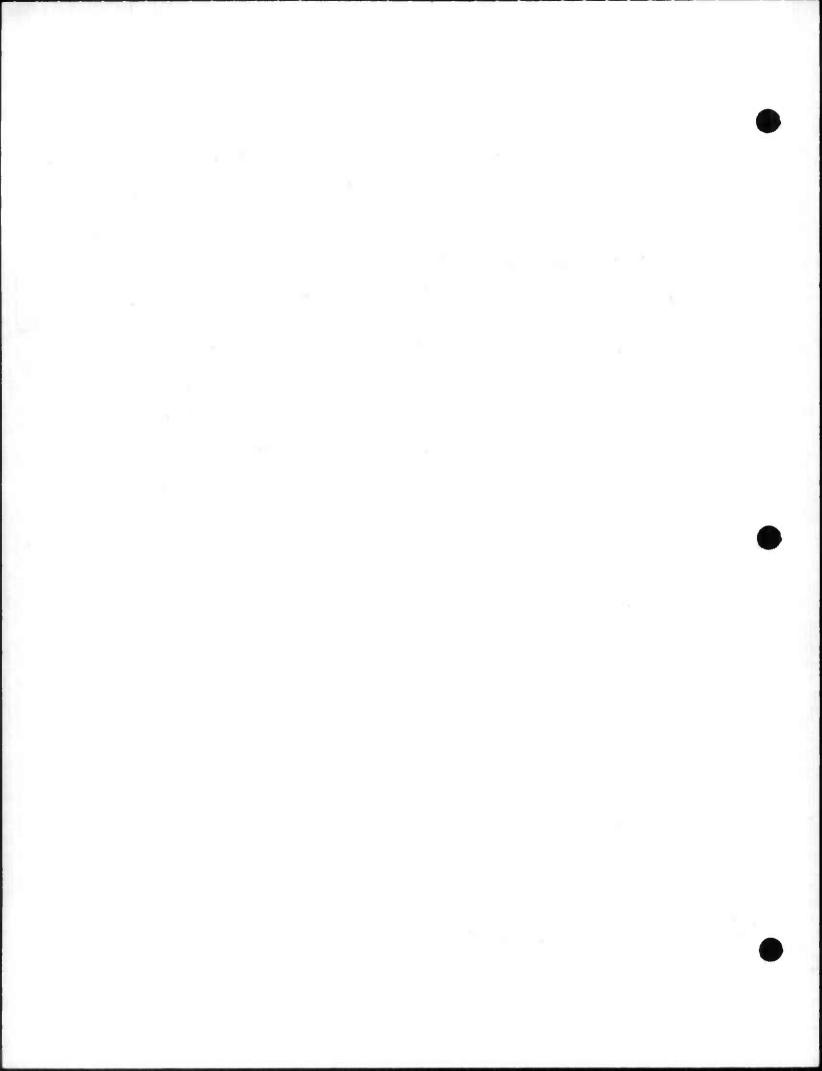
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or at	TO THE FUNERAL OIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use be filed within 72 hours after death with the State Dept. of Health and Mental Hypiene prior to burial, cremation, or removal.	IMPROPARITY IS how 90 in manufact as them 90 above one failure on other feature also as all the second states and the second states as a second state of the second states as a second state of the second states as a second state of the second states as a second state of the second states as a second state of the second states as a second state of the second states as a second state of the second states as a second state of the second states as a second state of the second states as a second state of the second states as a second state of the second states as a second state of the second states as a second state of the s
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	1 - FOR STATE REGISTRAR		STATE OF MA				F HEALTH		MENTAL HYGIEN REG. NO		
	1. DECEDENT'S NAME (First	l, Middle, Last)	SERMAIN) VOIG	_	BINGTO	_	2. DATE OF DEATH		3. TIME OF DEATH
	4. SOCIAL SECURITY NUM		5. SEX 8	1 N4	to N	-			7 2	7 9	5 19100 M
	577-24-8916		1 🗆 M 2 🚺	AGE (In yrs. Ins	YRS.		HOURS	R 24 HRS.	JUNE 15,19	14 Wa	ashington, D.C.
E E	90. FACILITY NAME (# not he Anne Arunde			2		Annap	WN OR LOCAT	ION OF DE	ATH		y of DEATH e Arundel
15	RESIDENCE OF DE	CEDENT								2411	z mandel
DIRECTOR	100. STATE Maryland	Princ	r ce Georges		10c. CITY	r, town or i		r Mai	rlboro		10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER Kingdom Far		1 Central	Avenue			10f. ZIP CO			10g. CITIZE	N OF WHAT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 3 Never Married 4 Divo		12. WAS DECEDENT E FORCES? 1 [] IF YES, GIVE WAR	YES 2 N		if yo	DECENDENT a, specify Cub YES 2 AND	an, Mexica	IIC ORIGIN? (Specify Yes n, Puerto Rican, etc.)		4. RACE — American Indian, Black, White, etc. Specify White
日日	15, DEC (Specify on	EDENT'S EDI	JCATION le completed)	16a. DE	CEDENT'S	USUAL OCCU	PATION og most of work	ina	16b. KIND OF BUS	SINESS/INDUS	STRY
once. COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT us	e retired.)	cialis		Floral	Indus	try
E 111	17. FATHER'S NAME (First, A Willia		old Landvoi	gt			18. MO1		ME (First, Middle, Meiden race Virgi		legler
examiner must be notified TO BE	Grace Angel		ington	191 Ki	ngdoi	address (si	1811	r or Rural F	noute Number, City or Town	n, State, Zip Co Upper	Marlboro, MD
	20a. METHOD OF DISPOSIT	on 3 🗆 Ren	novel from Stata	20b PLACE	ANDDATEO	E DISPOSITIO	N (Name of		DATE 200 10	CATION CI	hu or Town State
Ē	4 Donation 5 Other	(Specify)	CENSEE Datin F	McDo	Crem	atory	INC.	07/1	2/95 Balt	imore.	, MD
	► Dawn	7.mo	Donald	· ricboi	liaiu	Grema	ation :	Socie	ty of Mary	land,	Inc. D 21228
medical	23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardisc or reepiratory arrest, shock, or heart failurs. List only one ceuse on each line. Approximats interval Between										
2	IMMEDIATE CAUSE (Final disease or condition resulting in death) S								Onset and Death		
N avent	QUE TO OTA AS A CONSEQUENCE OF):										
CERTIFICATION	If sny, leading to immediate cause. Enter UNDERLYING										
TIFIC	CAUSE (Disease or injuthet initieted events resulting in death) LAS		C. DUE TO (OF	AS A CONSEC	DUENCE OF):					
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5 .	PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO										
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CA	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL	HOSPITAL:			H (Check only	one)				
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BY PI	1 Natural 5	Pending Investigation	(Month, Day,		INJU	JRY	WORK?] NO	286. DEŞCRIBE HOW II	NJURY OCCUP	RED
TED	3 Suicide 8	Could not be determined	28e. PLACE OF IN building, etc.	IJURY — At ho . (Specify)	me, farm, st	treet, factory,	office		281. LOCATION (Street a City or Town, Stete)	and Number or	Rural Route Number,
MPLE	29e. CERTIFIER (Check only	TIFYING PHYS	ICIAN: To the best of my	knowledge, de	eth occurre	d at the time,	data and place	, and due	to the cause(e) end men	ner ee stated.	
SO	(million)	_//	10	Instion end/or I	nvestigation	n, in my opini	on, death occu	red at the t	time, data end placa, en	d due to the c	cause(a) and manner as stated.
E H	296, BIOHATURE AND TITLE	OF CERTIFIE	Ille P	(-1	. 2) v.	29c. LIQ	ENSE NUM	BER DOL	29d. DATE S	MGNIPD (Month, Day, Year)
2	30. NAME AND ADDRESS OF	PERSON WI	Gull Gs	OF DEATH (ITEM	0	Print)	12 R	2.	Suiteza	20 P	tour all ma
	31. DATE FILED (Month, Day,	2 199	32. REGISTRAR'S	SIGNATURE		731	10.0	1	- VI/10 - V		S)/103
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		1 - FOR REGISTRAR	STATE OF MARYLAI		RTMENT OF H		MENTAL HYGIEN				
		1. DECEDENT'S NAME (First, Middle, Last)	D				2. DATE OF DEATH	VE40	3. TIME OF DEATH		
		Bessie	Brown				July 11	1995	10:00 A W		
		4. SOCIAL SECURITY NUMBER		yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	Cour	THPLACE (State or Foreign		
9		449-60-4322	1 M 2 XF 62	YRS.	WONTHS DATS	HOURS MIN.	7-17-3	32	"S.C.		
3 should	-	9a. FACILITY NAME (If not institution, give str	eer and number)		9b. CITY, TOWN	OR LOCATION OF D	EATH	9c. COUNTY OF	DEATH		
ام	١٥	RESIDENCE OF DECEDENT	<u> </u>		Da	140		NI	A .		
1.	DIRECTOR	10e. STATE 10b. COUNTY		10c. CI	Y, TOWN OR LOCA	TION			10d. INSIDE CITY		
2	품	M3.	NIA		Bal.	rimor	2		LIMITS?		
bermi	귛	10e. STREET AND NUMBER				r. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?			
physician. burial-transit permit, Pages 1,	FUNERAL	4812 Gr	eencrest	R	d.	212	06	US	A		
physician burial-tra	5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U FORCES? 1 YES	S. ARMEO	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specify Yes	s or No- 14. RAI	CE — American Indian, ck, White, etc.		
	ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATE	S		2 NO Specif	an, Puerlo Rican, etc.) ly:	- Son	ich:		
S S	ED E	15. DECEDENT'S EDUC	ATRON .	1- DECEMENTS	Hauss against				ack		
		(Specify only highest grade of Elementary/Secondary (0-12)	completed)	(Give kind of life. Do NOT u	WSUAL OCCUPATION Work done during most se retired.)	ost of working	186. KIND OF BUS	SINESS/INDUSTRY			
hospital or ached for u	2	Elementary/secondary (0-12)	College (1-4 or 5+)	0 (tome maker F			amily			
the hospit detached once.	COMPLET	17. FATHER'S NAME (First, Middle, Last)	4.4.1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			AME (First, Middle, Maiden	Surname			
8 & E	ш	Lewis	Nelson			Hat	tie P	riole	au		
5 should notified	8	19a. INFORMANT'S NAME (Type/Print)		_	ADDRESS (Street	and Number or Rural	Route Number, City or Tow.				
_ N _	일	Rev. Jakie	Brown, Jr.	197	18 B	ranch	leigh R	d. 2	1133		
2 2		20a. METHOD OF DISPOSITION 1 Burlei 2 Cremetion 3 Remo		LACE AND DATE	OF DISPOSITION (NE	ame of	OATE 20c. LO	CATION — City or 1	Town, Stata		
Page 6 ma il director, il ner must		4 Donation 8 Other (Specify)		Garri	Son Tole	2ST V. A	7/16 Ou	ings Mi	ls, Md.		
death. Pag tuneral dir I. Examiner		31. SIGNATURE OF FUNERAL SERVICE LICE	O Ja A		JO VA	NO ADDRESS OF FA	Morto	no-Se	ins		
		1 James	y. 11 fort	m	1.00	. 1	urens St	· Rolfo	Md. 21217		
hours after of in by the or removal		23. PART I. Inter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate									
Do de		IMMEDIATE CAUSE (Final			-i				Onset end Death		
		disease or condition resulting in death) Pulmonary Edema s. Pulmonary									
		DUE TO (OR AS A CONSEQUENCE OF):									
and con burial,	8	Sequentially list conditions, If any leading to immediate Due to (or As A consequence of): Sequentially list conditions, Due to (or As A consequence of):									
	CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING Acute Renal Failure									
Phy De y	윤	CAUSE (Diseese or Injury C	DUE TO (OR AS A CONSEQUENCE OF):					1 week			
eath certifica attending phy ntal Hygiene Y, or other		that initiated events resulting in death) LAST De 10 (OR AS A CONSEQUENCE OF): Proum an id									
A man		d.							1 3		
by the or Injury	Ä	PART II. Other significent conditions	contributing to death but	not resulting	in the underlying	g ceuse given in	Part I. 24a. WAS AN PERFOR	NICO .	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
uires that the signed by the Health and bws any in	MEDIC						1 YES 2	. NO	COMPLETION OF CAUSE OF DEATH?		
w requires been signe or, of Health	M								1 TES 2 TO NO		
law as b	PHYSICIAN:	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL					N 🗆 📗				
N: The ficate h State [S	EXAMINER?	HOSPITAL:		TH (Check only one) OTHER:						
SICIAN: The certificate in the State i, or item	14S	1 TYES 2 TO NO 27. MANNER OF DEATH	28s. DATE OF INJURY	ent 3 DOA			8 Other (Specify)				
NG PHYS fter this c path with marked,		1 🔀 Natural 5 🗌 Pending	(Month, Day, Year)		JURY WO	YES 2 NO	28d. DEŞCRIBE HOW II	NJURY OCCURED			
After death death	BY	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY —	Al home, farm,			281. LOCATION (Street a	and Number or Rural	Boute Number		
TTEN TOR: after 28 I	COMPLETED	4 Homicide 8 Could not be determined	building, atc. (Specify)	,			City or Town, State)				
OR A DIREC hours	E	29a, CERTIFIER 1 DE CERTIFYING PHYSIC	IAN: To the heat of my knowled	an death are	and and the others of the			on Bosses			
N N N	ME		IAN: To the best of my knowled On the basis of examination a						(s) and manner as stated		
		29b. SIGNATURE AND TITLE OF CERTIFIER									
표 표 를 중	8		ray M.D. Ho.	use Of	ficer	29c. LICENSE NUI		29d. DATE SIGNE	D (Month, Day, Year)		
5 5 3 X	2	30. NAME AND ADDRESS OF PERSON WHO			0.1.0	, 00	16	July	11 1995		
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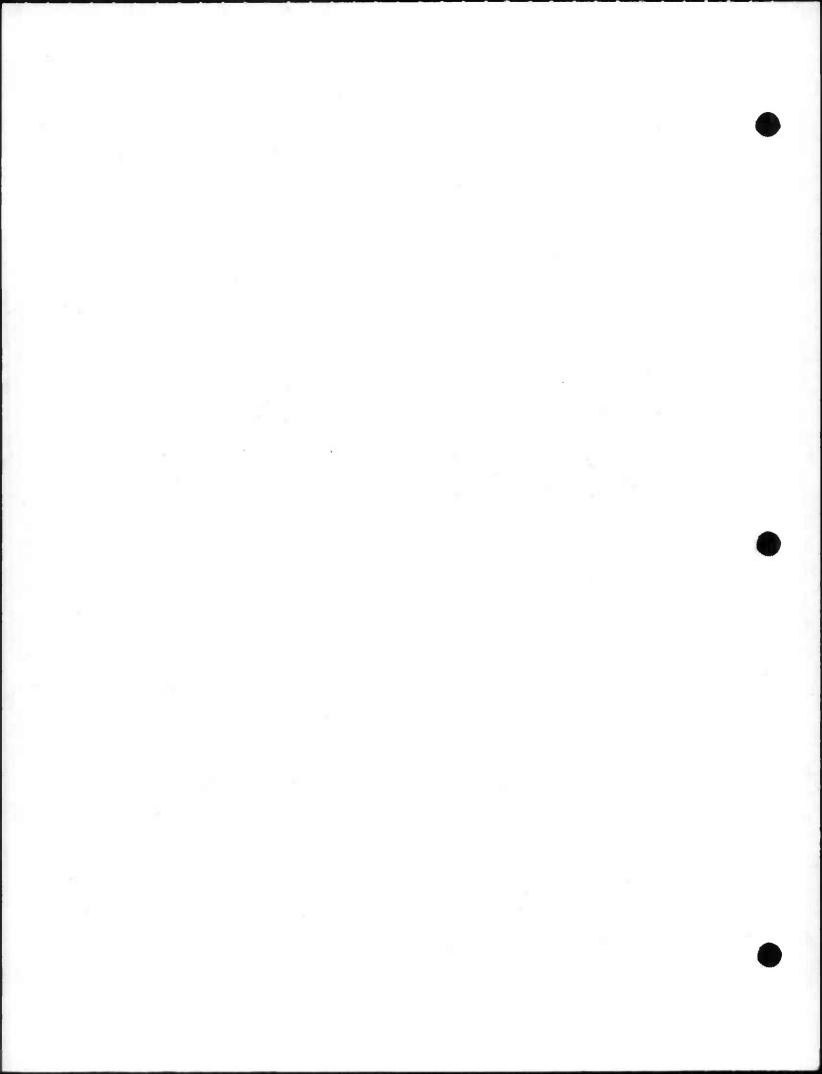


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	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remo	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medica
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	RECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Places 1, 2, 3 should		
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

VIRGIE BLANCHE BROWN 4. SOCIAL SECURITY NUMBER 5. SEX 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 90. FACILITY NAME (If not institution, give street and number) MERIDIAN CATONSVILLE NURSING HOME RESIDENCE OF DECEMENT 10a. STATE 10b. COUNTY MARYLAND BALTIMORE JULY 1 UNDER 1 YEAR F UNDER 24 HMS. 7. DATE OF BIRTH (Month, Day, Year) DEC. 23, 19 9b. CITY, TOWN OR LOCATION OF DEATH CATONSVILLE 10c. CITY, TOWN OR LOCATION LANSDOWNE	19 WE:	ST VIRGINIA										
579-22-6841 1 M 2 AF 75 VRS. MONTHS DAYS HOURS MIN. DEC. 23, 19 90. FACILITY NAME (If not institution, give street and number) MERIDIAN CATONSVILLE NURSING HOME CATONSVILLE RESIDENCE OF DECEDENT 100. STATE 100. COUNTY MARYLAND BALTIMORE 100. CITY, TOWN OR LOCATION LANSDOWNE	19 WE:	ST VIRGINIA										
96. FACILITY NAME (If not institution, give street and number) MERIDIAN CATONSVILLE NURSING HOME RESIDENCE OF DECEDENT 10a. STATE MARYLAND BALTIMORE 10c. CITY, TOWN OR LOCATION 10c. CITY, TOWN OR LOCATION LANSDOWNE	9c. COUNTY OF	ST VIRGINIA										
MERIDIAN CATONSVILLE NURSING HOME CATONSVILLE RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND BALTIMORE LANSDOWNE												
10a. STATE 10b. COUNTY MARYLAND BALTIMORE LANSDOWNE 10c. CITY, TOWN OR LOCATION 10c. CITY, TOWN OR LOCATION												
MARYLAND BALTIMORE LANSDOWNE 100. STREET AND NUMBER		10d. INSIDE CITY										
1 10t. ZIP CODE		1 TYES 2 NO										
324 WISEWELL COURT 21227	U.S	A.										
3 NWIdowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify:	Blec	14. RACE — American Indian, Black, White, etc. Specify: WHITE										
16. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. OECEDENT'S USUAL OCCUPATION (Specify only highest grade completed) (Give kind of work done during most of working	SINESS/INDUSTRY											
Elementary/Secondary (0-12) College (1-4 or 5 +) Iffe. Do NOT use retired.)	ND GLASS	CORPORATION										
17. FATHER'S NAME (First, Middle, Lest) CHESTER RAY SCHAFFER 18. MOTHER'S NAME (First, Middle, Melder	Surname)											
P CHESTER RAT SCHAFFER EDNA BLANCHE 190. INFORMANT'S NAME (Type/Print) FRED O'NEAL 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Tow P.O. BOX 411 — EDGEWATER, MD	vn, State, Zip Code) 21037											
20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of	CATION — City or To	own, State										
14) Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	LKRIDGE											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, I	NC .											
4107 WILKENS AVENUE-BAL		4D 21229										
23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, abock, or heart fellure. List only one cause on each line. Approximate interval Between												
IMMEDIATE CAUSE (Final disease or condition resulting in death) STROKE												
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Sequentially list conditions,												
cause. Enter UNDERLYING												
CAUSE (Disease or Injury that Initiated events resulting in death) LAST												
Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): 1. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN	PART II. Other algorificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY FINDINGS											
PART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. Multi-Infarct Dementia. 1 YES 2	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE										
	. Town	OF DEATH?										
7.												
25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)												
1 YES 2 NO 1 Inpetient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 Residence 6 Other (Specify)												
To return to produing N/A N/A 1 YES 2 NO N/A	ORK?											
	N/A.	Floute Number,										
29e. CERTIFIER (Check only (Ch												
29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and me one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end		a) and manner se stated										
(Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end me one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end of the cause(e) end me one)	nd due to the cause(
296. SIGNATURE AND TITLE OF CENTIFIER 296. LICENSE NUMBER D30469.	29d. DATE SIGNED	(Month, Day, Year) 12, 1995.										
296. SIGNATURE AND TITLE OF CENTIFIER 296. LICENSE NUMBER	29d. DATE SIGNED July	12, 1995.										



	1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle				ICATE OF		MENTAL HYGI REG. I	10.			
	HARRY JOHN						2. DATE OF DEATH MONTH JULY	DAY	year 95 9:10 P		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I	ast birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	1	. BIRTHPLACE (State or Foreign		
	199-09-4754	1 🕅 M 2 🗌 F	7	O YRS.	MONTHS DAYS	HOURS MIN.	10/01/1		PENNSYLVANIA		
	98. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH BEL FOREST NURSING HOME BEL AIR HARFORD										
RESIDENCE OF DECEDENT 10s. STATE 10s. COUNTY 10s. CITY TOWN OR LOCATION											
10000	MARYLAND	HARFORD		10c. CIT	y, town or loca FA	LLSTON			10d. INSIDE CITY LIMITS? 1 YES 2 NO		
ייייייייייייייייייייייייייייייייייייייי	10e. STREET AND NUMBER					. ZIP COOE		10g. CITIZE	EN OF WHAT COUNTRY?		
	1707 ABELIA	ROAD				2104	7		USA		
	11. MARITAL STATUS 1 Never Married 2 Marrie	12. WAS DECEDENT FORCES? 1	X YES 2		If yea, sp	ecify Cuban, Mexical	IC ORIGIN? (Specify n, Puarto Rican, atc.)	Yes or No- 1	4. RACE — American Indian, Black, Whita, atc.		
	3 Widowed 4 Divorced	IF YES, GIVE WA	WW II		1 TYES	2 XNO Specify	*		Specify: WHITE		
		T'S EDUCATION est grade completed)	1 (Give kind of v	USUAL OCCUPATION		16b. KIND OF	BUSINESS/INDU			
	Elementary/Secondary (0-12)	College (1-4 or 5+)		16. Do NOT US PRINTI			SUL	EL COME	NTV.		
	12th GRADE. 17. FATHER'S NAME (First, Middle, L	Lest)		KINII	247	18. MOTHER'S NAI	ME (First, Middle, Mak		PINI		
	WALTER BURHA	NN					ERNA BARI				
	190. INFORMANT'S NAME (Type/Prin	int)	1				loute Number, City or		ode)		
	BETTY BURHAN	N					ALLSTON,	MD 210)47		
	20b. PLACE AND DATE OF DISPOSITION 1 X Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE Of DISPOSITION (Name of cematery, crematory or other place) STGNAL HTLL MEM PARK 7/14/95 HANOVER, VA										
	21. SIGNATURE OF FUNERAL SERV		LSIGN	AT. HTI		PARK_ ID ADDRESS OF FAC	7/14/95_	HANOVE	ER, VA		
	1 2	19 1			JOHN	SON FUNE	RAL HOME				
	23. PART I. Enter the disease	ea, or complications that	ceused the d	leath. Do n	8521	LOCH RAT	VEN_BLVD	TOWS:	ON, MD 21286		
	shøck, or heert for IMMEDIATE CAUSE (Finel	ellure. List only one ceus	e on asch lin	ie.		, , , , , , , , , , , , , , , , , , , ,		, , , , , ,	Interval Batwee		
1	disesse or condition resulting in death)	m	14/6	0/0	Mue	loma			1 month		
1		DUE TO (C	OR AS A CONS	EQUENCE OF	7:						
	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):										
l	If sny, leeding to immediate cause. Enter UNDERLYING	}	-002.102 01	,				į			
	CAUSE (Disease or injury that initiated events		OR AS A CONSI	EOUENCE OF	7):						
	resulting in death) LAST	di									
	PART II. Other algnificent co	nditions contributing to d	leath but not	reaulting I	n the underlying	ceuse given in i	Part I. 24s. WAS	AN AUTOPSY	24b. WERE AUTOPSY FINDINGS		
								2 XNO	AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?		
							-		1 - YES 2 NO		
	DID TOBACCO USE C				S NO C	UNCERTAIN	1 20				
	EXAMINER?	HOSPITAL:			OTHER:	a S D Brettman					
	27. MANNER OF DEATH	28a. DATE OF II	NJURY	28b. TIMI	E OF 28c. INJ	e 5 🗆 Realdenca :	28d. DESCRIBE HO	W INJURY OCCU	REO		
1	1 Netural 5 Pendin 2 Accident Investig		, rear)	INJ		RK? /ES 2 NO					
į	3 Suicide 8 Could 4 Homicide datarm	building, at	INJURY — At h	ome, farm, s	treet, factory, offic		28f. LOCATION (Stre City or Town, Str	et and Number or ite)	Rural Route Number,		
	29a, CERTIFIER	DUMP CLAN TO A A A A A									
COMPL	(Check only	PHYSICIAN: To the beat of m XAMINER: On the basis of axa							, cause(a) and manner as stated.		
- 11	29b. SIGNATURE AND TITLE OF CE					29c. LICENSE NUM			GIGNED (Month, Day, Year)		
20	Mah	while !	25			d35.			14 10, 1995		
2	30. NAME AND ADDRESS OF PERS	ON WHO COMPLETED CAUSE					0.0-	1/4	117 12 (111)		

OMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

North Avenue

2. REGISTRAT'S SIGNATURE

2

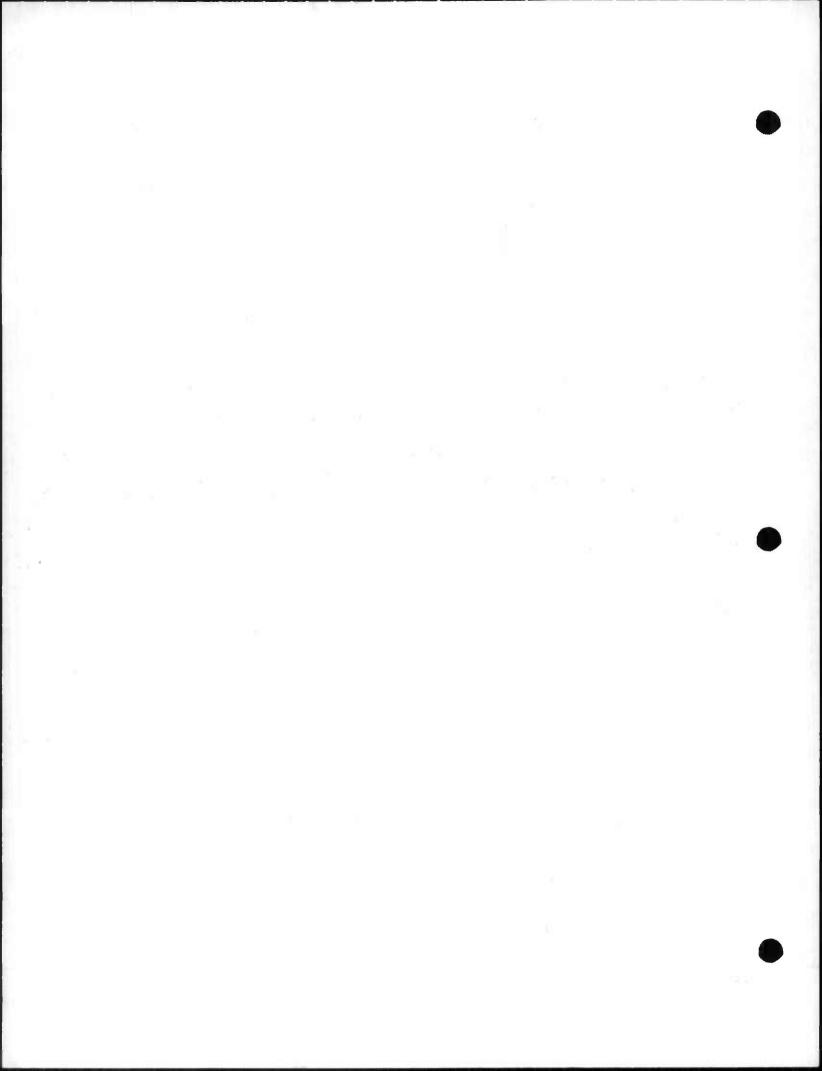
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1995



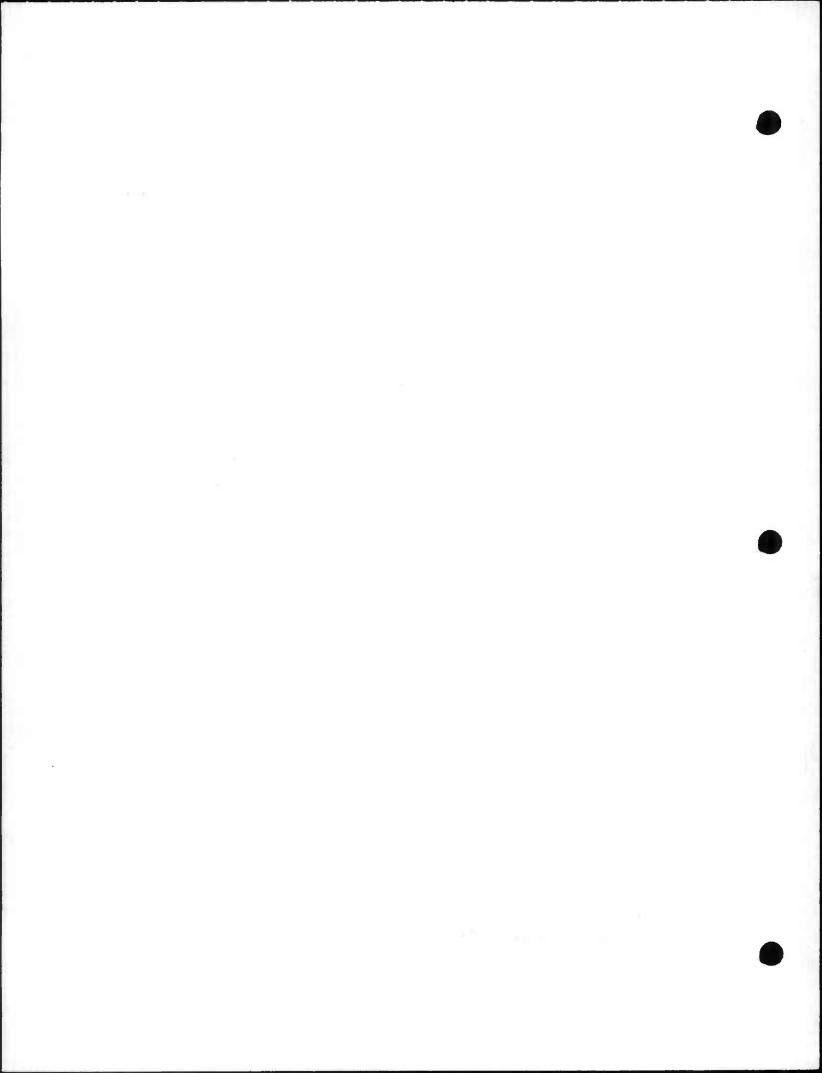
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TO THE HOSPITAL OR ATENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIFI	TMENT DF I	EALTH AND DEATH	MENTAL HYGI REG.				
	1. DECEDENT'S NAME (First, Middle, Lest) FRANKLIN	D ELANO		BROWN	SR.	2. DATE OF DEAT	"7th	MEAR	TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 229-38-5334	1 🔀 M 2 🗆 F	in yrs. last birthday) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Yea 04-12-19	1)	8. BIRTHPLI Country)	ACE (State or Foreign	
CTOR	98. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION GLEN BURNIE 90. CITY, TOWN OR LOCATION OF DEATH A.A. COURSEIDENCE OF DECEMENT									
DIRECTOR		NNE ARUNDEL	10c. CITY	SEVERN	TION			125	d. INSIDE CITY LIMITS? YES 2 NO	
FUNERAL	100. STREET AND NUMBER 1221 THOMPSON AVE				21144			U.S.A		
B≺	11. MARITAL STATUS 1 Never Merried 2 X Married 3 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes, sp	ENDENT OF HISPA ecify Cuben, Maxica 2 NO Specif	NIC ORIGIN? (Specify in, Puerto Ricen, etc. y:	Yes or No	14. RACE — American Indian, Black, Whita, atc. Specify: WHTTE		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) Coffege (1-4 or 5+) N/A	16a. DECEDENT'S I (Give kind of w life. Do NOT use WELDE	ork done during me retired.)	ON est of working	-5.5.005.00	BUSINESS/IND	DUSTRY	VIII 4 13	
BE COM	17. FATHER'S NAME (First, Middle, Last) LESTER BI		ROWN, SR.		18. MOTHER'S NA	ME (First, Middle, Ma				
10	198. INFORMANT'S NAME (Type/Print) BETTY ANN BROWN					Route Number, City or SEVERN				
	20a. METHOD OF DISPOSITION ☐ Buriel 2 ☐ Cremetion 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC	ovel from State cerr GI	PLACE AND DATE O letery, crematory or off EN HAVEN	her place) I MEMORI		7/11 GI	LOCATION —			
	Michael	1 C. Ja	Shan	1 SEC	OND AVEN	SINGLE: UE, S.W.	GLEN B	BURNIE	HOME ,MD. 21061	
	23. PART I. Enter the diseases, or shock, or heart fellure. IMMEDIATE CAUSE (Finel disease or condition resulting in desth)	disease or condition								
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):									
Ä	PART II. Other significant conditions contributing to deeth but not reaulting in the underlying cause given in Part I. Chrinic Obstructive Kulmenus Lisease 1 yes 2 Tho							AM CO OF	RE AUTOPSY FINDINGS ALLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO	
PHYSICIAN: MEDIC	DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE OF DEATH	H (Check only one)	UNCERTAI	N 🗆				
HYSI	1 YES 2 JAO 27. MANNER OF DEATH	HOSPITAL: 1 Inpetiant 2 ER/Outp 26a. DATE OF INJURY				6 Other (Specify) 28d. DESCRIBE HO	W N HIPV OO	NIBED		
BY P	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU		RK?	200. DESCRIBE IN	W INJUNT OCC	JONEO		
- 4	3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, etc. (Spec	— At home, ferm, st	treet, factory, offic		281. LOCATION (Str City or Town, S	set and Number (ate)	or Rural Route	Number,	
COMPLETED		CIAN: To the best of my knowler. On the basis of examination							d manner as stated.	
TO BE C	29 Signature and title of cultiple	edann	14.9		29c. LICENSE NUI	MBER /		E SIGNED (Ma	onth, Day, Year)	
	DR. BENJAMIN B	ERDANN/606 H	AMMONDS I	LANE/BAI	TIMORE, M	ID 21025				
	JUL 1 2 1995	L. HEREBERA GAR	TIME					-		



95 20920

		Item4,g-725,7-12-95, FOR 1 - STATE			AND / DEPAR	RTMENT (OF H	EALTH	AND N	/ENTA	L HYGIEN	E	e	1.4 () () (a)
		REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)	OLIMINATE OF DEATH								REG. NO			
		MARSHALL	т	EE						2. DATE OF DEATH MONTH DAY		AY	YEAR	3. TIME OF DEATH
		7	S. SEX		In yrs. last birthday)	IF UNDER 1 Y		IF UNDER	24 HRS	JU 7 DATE	OF BIRTH	/	95	3:31 Pu
		unknown 242-54-0581		11.	57 YRS.		MYS	HOURS	MIN.	(Mont	n. Day. Year)	38 R	Country) OWAN	
3 should		Se. FACILITY NAME (If not institution, give street				96. CITY, TO	OWN O	R LOCATE	ON OF DE		,	9c. COUNT		7
2, 3	OR	FRANKLIN SQUARE	HOSPI	TAL			ROS	SSVI	LLE			BALT	ГІМС	RE
	딢	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			10c CIT	Y, TOWN OR I								
3	L DIRECTOR	MARYLAND 104. STREET AND NUMBER	n/	a	100.01		BAL	TIMO					1	IOd. INSIDE CITY LIMITS? I YES 2 NO
DR)	WERAL	1115 E. RICKEN	IBACKER				101. ZIP CODE 21221					UNITED STATES		
215-0070 attending male ise as the investigation	BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed & Divorced	IF YES, GIVE WAR OR DATES			If ye	13. WAS DECENDENT OF HISPANIC ORIGIN: If yes, specify Cuben, Mexicen, Puerto R 1 YES 2 XX XO Specify:				to Ricen, atc.) Black,			- American Indian, White, etc. - BLACK
r attenduse as	ED	15. DECEDENT'S EDUCA (Specify only highest grade co	FION (hpleted)		16a. DECEDENT'S	USUAL OCCL	JPATIO	N it of workin	a	168	KIND OF BUS	SINESS/INDU	STRY	
Q = 5	COMPLET	12 th	College (1-4 or 5	+)	LABC	work done duri se retired.) RER					CON	ISTRUC	TION	
YLA by the be def	BE CO	17. FATHER'S NAME (First, Middle, Lest) TILLMAN BROWN						18. MOTE	SAR.	AE (First, AH	Middle, Maiden SIMPS	Sumame)		
	5	190. INFORMANT'S NAME (Type/Print) TILLMAN BROWN	JR.		19b. MAILING 1206						ber, City or Town ISBURY			LINA 28144
6 may ctor, pa		20s/METHOD OF DISPOSITION 1	from State	20b. ceme	PLACE AND DATE	OF DISPOSITION	Nen (Nen	PAR	K	7-1		CATION — CI		AROLINA
ALT r death. e funer al. exam		21. SIGNATURE OF FUNERAL SERVICE LICEN	LA &	tole	land	22. NAI	ME ANI	C. M	ARCH	F	1101 BALT		NOR MD	TH AVENUE 21202
of within 24 hours completely filled in the co	23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiac or reepiratory arm shock, or heart failure. List only one couse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (DR AS A CONSEQUENCE OF):									ratory arre	it,	Approximate interval Between Onset and Death		
S, P.O. BOX 6870 death certificate be executed a attending physician and con ental Hygiene prior to burial, iry, or other traumatic er	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (DR AS A CONSEDUENCE DF): DUE TO (DR AS A CONSEDUENCE DF): d.												
RECORDS requires that the been signed by the c. of Health and M shows any Inje	MEDICAL	PART II. Other significent conditions of the part of t								_	24a. WAS AN PERFOR 1 YES 2	MED?	0	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO
AL The law te bept te Dept	N.	25. WAS CASE REFERRED TO MEDICAL			6. PLACE DF DEA								1	
ICIAN: The ertificate the State or item	l Sic		OSPITAL:	XER/Outpa	ntiant 3 🗆 DOA	OTHER:	Home	5 🗆 Re	aldenca 8	□ Othe	r (Specify)			
NG PHYSIC fler this cereath with the	BY PHYSICIAN:	27. MANNER DF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF (Month, D		28b. TIM	URY	C. INJU WOR	RY AT RK? ES 2		28d. DES	CRIBE HOW IP	NJURY OCCU	RED	
TTENDI TTOR: A after da	요	2 Accident investigation 3 Suicide 6 Could not be determined	28e. PLACE O building,	F INJURY - atc. (Specia	— Al home, larm, a	etreet, factory,	office			28f. LOC City	ATION (Street a or Town, State)	nd Number of	Rural Rou	te Number,
로 크 스 트	COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA 2 MEDICAL EXAMINER:												and menner as stated.
FUN With	E C	29h. SIGNATURE AND SPILE OF CENTIFIER	0 /	0.0					NSE NUMI					fonth, Day, Year)
TO THE HOSPIT TO THE FUNERA be filed within 7	TO BE	News 30 NAME AND ADDRESS OF THE STREET	4.0	hu	temo	4			C.M.					8,1995
		30. NAME AND ADDRESS OF PERSON WHO O	CAUSE CAUS	SE OF DEA		31100000	tre	et,	Ba	ltir	nore,	Mary	lan	d 21201
		31. DATE FILED (Month, Day 1997) 1995	Java 6	S SIGNA	TURE Randall									

-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the INTREMENTAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detuined to filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at one DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - FOR STATE REGISTRAR	STATE OF MA	ARYLAND	/ DEPAR	TMENT CATE	OF H	EALTH	AND	MENT	AL HYGIE			
	1. DECEDENT'S, NAME (First, Middle, Last)	BROWN	1						MON	E OF DEATH	DAY	O SEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	T	AGE (In yrs.	rry Lei	FUNDER 1				7		9	75	77.55 / H
- 1	218-42- 2545	1 €XM 2 □ F				DAYS	IF UNDER	MIN.	(Moi	E OF BIRTH oth, Day, Year)	30,194	Countr	PLACE (State or Foreign y) IARYLAND
	90. FACILITY NAME University	/			96. CITY, 1	TOWN C	R LOCATIO	ON OF D	EATH		9c. COU	NTY OF D	EATH
TOR	UNIVERISITY RESIDENCE OF DECEDENT	HOSPITA	AL .			BAI	TIMO	RE	CI	TY		n	ı/a
DIRECTOR	Maryland MSRYTAN	n/a		10c. CITY, TOWN OR LOCATION					Ва	ltimore		-	10d. INSIDE CITY LIMITS? 1 XXYES 2 NO
AL.	10e. STREET AND NUMBER						ZIP CODE				10α, CITI	ZEN OF V	WHAT COUNTRY?
FUNERAL			NUE			_	212		2		UNI		TATES
B	11. MARITAL STATUS Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT (FORCES? 1 FYES, GIVE WAS	YES 2	ARMED	14	yes, spe	ENDENT O	n, Mexica	in, Puarto	IN? (Specify Your Rican, etc.)	es or No—	14. RACE Black Speck	— American Indian, White, etc.
BRED	16. DECEDENT'S EDUC (Specify only highest grade	CATION completed)		DECEDENT'S (Give kind of	work done du	UPATIO	N If of workin	0	16	b. KIND OF B	JSINESS/INC	USTRY	
NO SE	Elámentary/Secondary (0-12) 7 TH	College (1-4 or 5+)		ife. Do NOT u	se retired.)								
	17. FATHER'S NAME (First, Middle, Last)			SEI	.r- r	JAIL	OYEL				ARAB		
E CD		BROWN					18. MOTE	ETHI		Middle, Maide		C	
0	19a. INFORMANT'S NAME (Type/Print)	DICOVILY	1	19b. MAILING	ADDRESS (Street a	nd Number			MARY nber, City or To	TIBB	-	
임	MURIEL TUCKER	2		1227									YLAND 21213
	20a, METHOD OF DISPOSITION		20b.PLAC	E AND DATE				DIK	DA		OCATION -		
	4 ☐ Donation 5 ☐ Other (Specify)	oval from State	MT .	ZION	ther place)	ETE	RY						, MARYLAND
	21. SIGNATURE OF FUNERAL SERVICE LIC			1		_	D ADDRES	S OF FA			DI II (IOD	OTTEL	/ TRACEDATED
	J. Valen	cia Ho	ela	nd		WM.	C.	MAR	CH F	H110	1 E.	NOR	TH AVE
	23. PART I. Enter the diseases, or of ahock, or heart fellure.	complications that of List only one cause	aused the o	deeth. Do i	not enter ti	he mo	de of dyl	ng, suc	h aa ca	rdiac or real	piratory arr	eat,	Approximata interval Between
	IMMEDIATE CALISE (Final		4		FN	200	100	7.	7/5				Onset and Death
- 1	readiting in death)	STAPH DUE TO (O	R AS A CONS	EQUENCE O	F):		1		, , ,				
z l	Sequentielly list conditions,					_/	430	ISE					
¥	If any, leeding to immediate cause. Enter UNDERLYING	DUE TO (O	R AS A CONS	EQUENCE O	F):								
	CAUSE (Disease or Injury	DUE TO (Q	R AS A CONS	EQUENCE O	P.								-
CERTIFICATION	that initiated events resulting in death) LAST			EGOENOE O	i.								ĺ
빙		£										_	
SP	PART II. Other significent condition	g contributing to de	eeth but not	resulting	in the unde	erlying	cause g	iven In	Part I.	24a. WAS AI PERFO	NAUTOPSY RMED?	246.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
MEDICA										1 🗆 YES	2 NO		OF DEATH?
Σ	DID TOBACCO USE CONTR	PIRLITE TO CALL	SE OE DE	ATLI VE	S \square N		LINIC	ERTAI	1				1 TYES 2 NO
Y Y	25. WAS CASE REFERRED TO MEDICAL	TO CAO		ACE OF DEAT		_	OIAC	EKIAII	VA.				
Sic	EXAMINER?	HOSPITAL:	R/Outpatient	3 DOA	OTHER:	o Home	6 🗆 Ber	Idenos	e [] Au	/0/-			
I 27. MANNER OF DEATH 280. DATE OF INJURY 280. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED													
BY	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,	Tear)	INJ	M	1 Y		NO					
	3 Suicide 8 Could not be detarmined	nome, farm, s	e, farm, street, factory, offica				281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				oute Number,		
MPLET	29a. CERTIFIER CERTIFYING PHYSIC	CIAN: To the best of my	, bassuladas ,	death assum						and a const			٠,
ME	(Check only one) 2 MEDICAL EXAMINER												and manner as stated.
8	296. SIGNATURE AND TULE OF CERTIFIER					_	**						
O BE	AULUI	IDENT A	DHYS	CIAN	/		PC PC	7	75	6	▶ 7	161	(Month, Day, Year)
=	MANUAL AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH (IT	EM 27) (Type,		1).			m	rever	1 >	11	-0 -1
	31. DATE FILED (Month, Day, Year)	32. JEGISTRARY	SIGNATURE	1, 5.	- (/N	10- 6	or.	////	regul	no	170	SP.TAL
	1 2 1995	Jalia da	uchark	ardall									

XX

MT. ZION

of. Valence a Holland

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

		HEGIS I HAH				UE	RITE	CALL	: UF	DEA	IH		REG. NO.			
	ij	1. DECEDENT'S NAME (First, M		TNICON	am	TORT	ANT						8,1º	005	VEAD	TIME OF DEATH
		ALBERTHA 4. SOCIAL SECURITY NUMBER		INSON I		ISTI		E IMPER	1 7540	- mare						:45 P.M.
P		219 42 573	9	□ M 2 X F		60	YRS.	IF UNDER	DAYS	IF UNDER	MIN.	DEC.	DE BIRTH	934	SOUTH	CAROLIN
2, 3 should	DIRECTOR	96. FACILITY NAME (If not institution, give street and number) 2517 SHIRLEY AVENUE BESIDENCE OF DECEDENT 96. COUNTY/OF DEATH BALTIMORE 96. COUNTY/OF DEATH BALTIMORE									Н					
Jes 1,	l Di	10a. STATE 1		10c. CITY	, TOWN C	OR LOCA	TION					10	d, INSIDE CITY			
rmit. Pag		MARYLAND 100. STREET AND NUMBER	В,	'A]	BALTIMORE						1,	LIMITS? YES 2 NO	
physician. burlal-transit permit. Pages 1, 2,	FUNERAL	2517 SHIRI								2121				U.S.		A.
	B	11. MARITAL STATUS 1 Never Married 2 Ma 3 Widowed 4 Divorce	irried	2. WAS DECEDENT FORCES? 1 IF YES, OIVE W	YES	2 NO	ED)		f yes, sp	CENDENT Codes	n, Mexicer	i, Puerto R	? (Specify Yes lcan, etc.)	or No	Black, W	American Indian, hita, etc. BLACK
r attending use as the	9	15. DECED (Specify only hi	ENT'S EDUCAT	TON (mining)		16a. DECI	EDENT'S	USUAL O	CUPATI	ON .		16b.	KIND OF BUS	SINESS/IND	USTRY	
spital o	COMPLETED	Elementary/Secondary (0-12 12TH		College (1-4 or 5+)	SEA	MSTI	RESS	Suring me	ost of workin	og .	C	LOTH	ING		
by the be det	ш	17. FATHER'S NAME (First, Middle, Leat) LANDY ROBINSON 18. MOTHER'S NAME (First, Middle, Maiden Surname) LUCILLE PARKER										1. 19				
be retained ge 5 should e notified	TO B	190. INFORMANT'S NAME (Type THEODORE (TIAN		19b. 2	MAILING 517	ADDRESS SHI	(Street a	er A	VE.	BA	LTÖ,	AD.	2 1 215	5
2 2		20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 4 Donation 5 Other (Sc	3 - Remova	I from State	20t cen D	PLACE AN	DDATEO	FDISPOS Der place) DGE	CEI	M. 7	/15	/ 9 5			Sty or Town,	State IARYLAND
ter death. Page 6 m the funeral director, val.		21. SIGNATURE OF FUNERAL S		LEW!	TC '		WYNI	N 22.	NAME AL	S T.	SS OF FAC	YNN	FUNE	RAL I	HOME	21215
rs after d removal.		23 PART I Enter the dise	****	suyn,	v	el ébo eloce	h Dan						TS AV).,MD.
24 hou filled in on, or he me		23. PART i. Entar tha dise ahock, or hast iMMEDIATE CAUSE (Final disease or condition resulting in daeth)	t fallure. Lis	t pni) one caus	se on a	ach line.	un. Do ne	Cantar	lo de	7~	ng, such		M.			Approximata Interval Batween Onset and Daath
D 2 - 9	z			DUE TO (OR AS	A CONSEQU	ENCE OF):	-		-					
sician a	CATIO	Sequentially list condition if any, leading to immedia cause. Enter UNDERLYING	ta	DUE TO (OR AS	CONSEQU	ENCE OF):								
h certifica ending ph Hygiene or other	CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST		DUE TO (OR AS	CONSEQU	ENCE OF):								
the death y the atte nd Mental Injury,		PART II. Other aignificant	conditions	ontributing to	death h	eut not rei	witing ir	the un	declyin	2 091190 0	due in f	Daret I	24a. WAS AN	ALFTONOV		
uires that the signed by Health and ws any Ir	EDICAL									g cause g	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		PERFOR	MED?	AW	RE AUTOPSY FINDINGS ILLABLE PRIOR TO MPLETION OF CAUSE DEATH?
e law requi has been s Dept. of H		DID TOBACCO USE	CONTRIB	BUTE TO CAL	JSE O	F DFATI	H YES	. П г	JO [1 LINC	ERTAIN	_			1 (YES 2 NO
V: The law icate has t State Dept item 23	SIAP	25. WAS CASE REFERRED TO M	EDICAL			26. PLACE				2 0110	EKIMI					
ician: The sertificate by the State or item	PHYSICIAN: M	1 X YES 2 NO		OSPITAL:	ER/Outp	patient 3		OTHER		5 XRa	sidence (□ Other	(Specify)			
PHYS this with	ву рн	27. MANNER OF DEATH 1 Natural 5 Per 2 Accident	iding stigation	28e. DATE OF I (Month, Da	INJURY y, Year)		26b. TIME INJU	OF IRY M		URY AT PRK? YES 2		28d, DE\$(CRIBE HOW IN	JURY OCC	URED	
OR ATTENDING DIRECTOR: After hours after death		3 Suicide 6 Cou	uld not be	28e. PLACE OF building, a	INJURY Itc. (Spec	— At home	e, term, st	reet, facto	ory, offic	0		28t, LOCA City o	TION (Street au Town, State)	nd Number o	or Rural Route	Number,
보 기 시 =	COMPLETE			N: To the beat of r												d manner as stated.
TO THE HOSPIT TO THE FUNERA De filed within 7	BE	29b. SIGNATURE AND TITLE OF	CENTIFIER	34.0	7				1	29c. LICE	NSE NUM	BER		29d. DATE	SIGNED (Mo	nth Day, Year)
	10	30. NAME AND ADDRESS OF PE	AL CO	OMPLETED CAUSE	OF DE	ATH (ITEM	27) (Type, I	Print)	21	06	1	, - , , , ,	(. 6		a //	13 K
		31. DATE FILED (MOOTH, DO 95	Juli	32 REGISTRAR	'S STEN	ATURE		7 60	Caro	y		- or A		agast	- lack	00 (0
			0			-14-(14)										

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D THE HOSPITAL OR O THE FUNERAL DIF E filed within 72 hou MPORTANT: If Itel		TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tranet na	be field within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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mit. Pages 1, 2, 3 should

	1 - STATE REGISTRAR	STATE OF MARYL			HEALTH AND	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle					2. DATE OF DEATH		3. TIME OF DEATH	
	FRANCIS J. C	ONNOLLY				JULY 7, 1	995 YEAR	23:02 P M	
	4. SOCIAL SECURITY NUMBER 130-12-2648	7. DATE OF BIRTH (Month, Day, Year)	8. BIR	THPLACE (State or Foreign					
		1-16 M 2 🗆 F	80 YRS.	MONTHS DAYS		Aug 5, 19	14 New	York	
œ	9a. FACILITY NAME (If not institution St. Agnes Hos)				on Location of D Baltimore		9c. COUNTY OF		
DIRECTOR	RESIDENCE OF DECEDE				Darcinore		14/	A	
RE		COUNTY	10c. CITY	TOWN OR LOC				10d. INSIDE CITY LIMITS?	
	Maryland	Baltimore		Caton	sville			1 TYES 2 NO	
FUNERAL	100. STREET AND NUMBER 719 Maiden Cl	hoice Lane	BR 128		101. ZIP CODE 2122	8		S.A.	
11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No.— 14. RACE — American Indian,									
IF YES GIVE WAR OR DATES									
D BY	11 11 11 11 11 11							White	
COMPLETED	(Specify only highe	T'S EDUC/ITION ost grade completed)	16e. DECEDENT'S L (Give kind of we life. Do NOT use	ork done during i	TION nost of working	16b. KIND OF BUS	SINESS/INOUSTRY		
2	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+	Director	Of	ricos	Washi	ngton Co	nıntv	
∑	17. FATHER'S NAME (First, Middle, L	Last)	Socia	r ser	/ices	AME (First, Middle, Malden		, care y	
BE C	Patrick Domini	ic Connolly			Mary Mc		333337		
2	19e. INFORMANT'S NAME (Type/Pri	,		ADDRESS (Stree	t end Number or Rural	Route Number, City or Town	n, State, Zip Code)		
		uayle (Daughter)				altimore, 1	Maryland	21214	
	20e. METHOD OF DISPOSITION 1X Burlet 2 Cremation 3	☐ Removal from State 201	o. PLACE AND DATE OF the control of	er place)	july 11,	1995TE 20c. LO	CATION — City or		
	4 Donetion 5 Other (Special Signature OF FUNERAL BERN	m)IHC	otà Kedeei	mer Cer	NETERY AND ADDRESS OF FA	Bali	timore, M	aryland	
-		1.0	1/2	Leroy	M & Rus	sell C Wit:			
4		es, or complications that cause	*	1630	Edmondso	n Avenue Ca	atonsvil	le,Maryland	
	anock, or neart to	allure. List only one ceuse on e	ach line.	ot enter the n	iode of dying, auc	th as cerdiac or respi	ratory arrest,	Approximate Interval Between	
	IMMEDIATE CAUSE (Finel disease or condition	Athero	cillinda	- /	asellowers	cular Di	SPAIR	Onset and Death	
ł	resulting In death)		CONSEQUENCE OF	:	0.0000000	ana v	server.	coyears	
z									
RTIFICATION	Sequentially list conditions, if any, leading to immediate	OUE TO (OR AS	CONSEQUENCE OF)	:					
	cause. Enter UNDERLYING CAUSE (Disease or Injury	C. OUE TO (OR AS	CONSEQUENCE OF						
	that initiated events resulting in death) LAST		· OUNDEDUCTOR OF					i	
5	PADT ii Other elevitions on								
8	PART II. Other algrinicant con	nditions contributing to death b	1	/	ng ceuse given in	Part I. 24s. WAS AN PERFOR		b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO	
	1 fr	ial Fibrilla	tion	we		1 TYES 2	NO	COMPLETION OF CAUSE DF DEATH?	
Σ	DID TORACCO USE C	CONTRIBUTE TO CAUSE C	7	□ NO I	UNCERTAI	N D		1 TYES 2 TO NO	
HYSICIAN: MEDIC	25. WAS CASE REFERRED TO MED		26. PLACE OF DEATH			AI			
	EXAMINER?	HOSPITAL:		OTHER:	me 5 🗆 Residence	6 ☐ Other (Specify)			
E	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	26b. TIME INJU	OF 28c. II	JURY AT	28d. DESCRIBE HOW II	JURY OCCURED		
5	Natural 5 Pendin	gation		M 1	YES 2 NO				
- 11	3 Suicide 6 Could 4 Homicide determ		— At home, ferm, str cify)	reet, fectory, of	Ice	281. LOCATION (Street e City or Town, State)	nd Number or Rura	Route Number,	
	29e. CERTIFIER								
COMPLEIED	(Check only	PHYSICIAN: To the best of my know XAMINER: On the bests of examination						(A) Total Transition	
. 11	20h SIONATIIDE MID/TITLE OF CERTIFICIAL A								
H H	/Allille	4 House	u)		7) 38	5U2	29d, DATE SIGNE	(Month, Day, Year)	
2	30. NAME/ANO AODRESS OF PERS	ON WHO COMPLETED CAUSE OF OR	ATH (ITEM 27) (Type, I	Print)	1000	7/	Jul	, ,0,1975	
	KEVIN H.	scrubus uni	900	Cator	n Aven	we Bu	timore	, Mary land	
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE						
	JUL 1 2 1995) facts or marian	TO ALL						

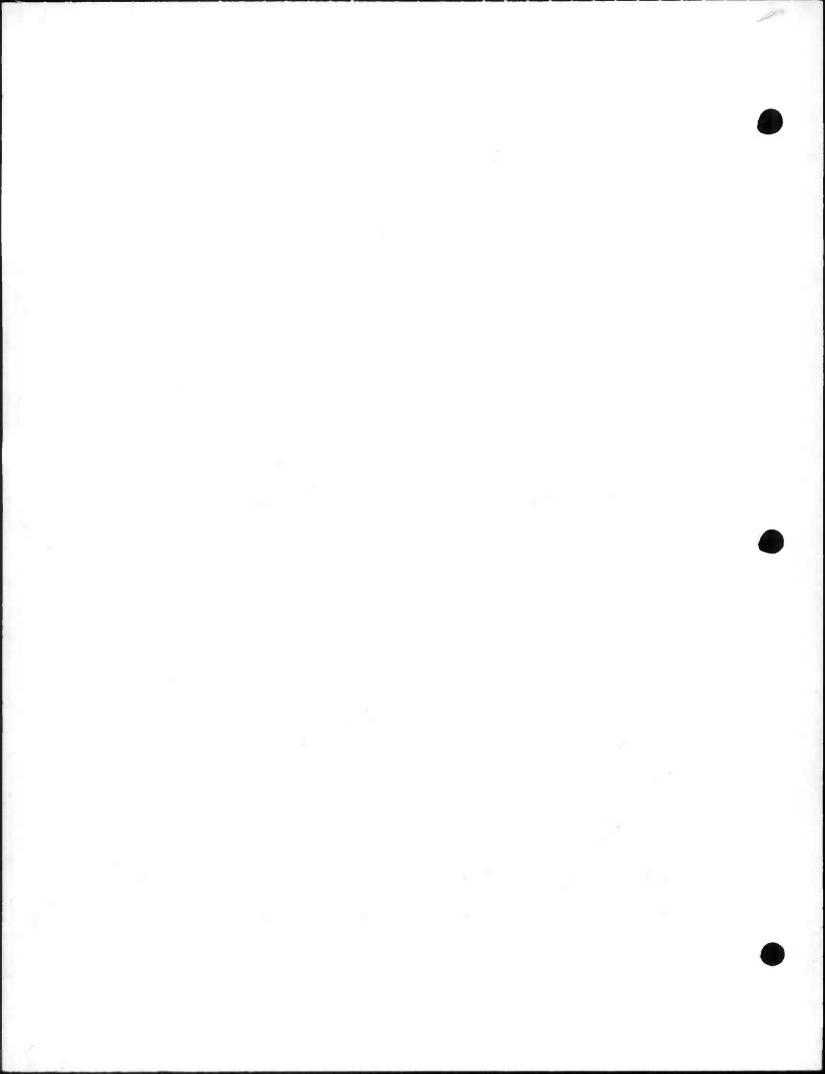
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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th certifica	certificate has been signed by the attending physician and the State Dept. of Health and Mental Hygiene prior to
CIAN: The law requires that the death certifical	tificate has been signed by the attendir e State Dept. of Health and Mental Hyg
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The law re	te has been the Dept. of
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FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	REGISTRAR	CERTIFIC	CATE OF	DEATH	R	EG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last)			-	2. DATE OF I				3. TIME OF DEATH		
	Lisa E. Canada				MONTH	DA		YEAR	5m Pu		
ľ		yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF E	9	, 1	995	PLACE (State or Foreign		
	214-86-2173 1 N 2 XF 2:	_	PONTHS DAYS	HOURS MIN.	(Month, Da	y, Year)		Country	y)		
~	9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH										
CTOR	10 Chester Circle Glen Burnie Anne An										
5	RESIDENCE OF DECEDENT										
DIRE	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10c.										
	Md. N/A	Ba	altimore	9					LIMITS?		
A	10e. STREET AND NUMBER		101.	ZIP CODE			10g. CITI	ZEN OF Y	HAT COUNTRY?		
1 6	313 S. Norris St.			21223				USA			
FUNER	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U	J.S. ARMED	13. WAS DEC	ENDENT OF HISPAI	AIC OBIGINS (S.	anoifu Van			- American indian,		
	1 Never Married 2 Married FORCES? 1 YES		If yes, spe	cify Cuban, Mexica	n, Puerto Rican		0, 100—	Black	, White, etc.		
B	3 Widowed 4 Divorced IF YES, GIVE WAR OR DATE	E\$ · ·	1 TYES	2 NO Specify	y:			Speci	white		
8	15. DECEDENT'S EDUCATION 1	6a. DECEDENT'S U	PULL OCCUPATIO		441 1411		1				
	(Specify only highest grade completed)		rk done during mos		160. KIN	D OF BUS	INESS/IND	USTRY			
1 5	Elementary/Secondary (0-12) (College (1-4 or 5 +)		,		_						
9 ₹	7 N/A	Waitres	SS		Foc	od Se	rvic	e			
once. COMPLET	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NA	ME (First, Middle	, Maiden S	Sumame)				
the medical examiner must be notified at once. TO BE COM	Johnny L. Canada			Made	line M.	Tul	1				
	19e. INFORMANT'S NAME (Type/Print)	19b. MAILING A	DDRESS (Street at	nd Number or Rural I				Code)			
일	Johnny L. Canada			Ave., Mir			2754				
2		LACE AND DATE OF					_				
100	1 Buriel 2 Cremation 3 Removal from State camele	ery, crematory or othe	er place)		DATE		ATION —	-			
E	4 Donation 5 Other (Specify)	udon Par	ck Cemet	ery	7/12	Ral	timo	re,	Md.		
틢	21. BIOMATURE OF PORESIAC SERVICE CICENSEE	11		D ADDRESS OF FA		-		-			
ž X	Gary L. Kaufman Funeral Home of Elk., Inc.										
63	23. PART i Enter the diseases, or complications that caused the	be death Dd as	15695 M	lain St.	Elkri	dge.	Md.	21			
Bell	23. PART I. Entar the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death										
9	IMMEDIATE CAUSE (Fine)	1	7						Onset and Death		
튀	disease or condition a. Hepatic	Faile	ue						/ weeks		
or other traumatic event, ERTIFICATION	DUE TO (OR AS A C	ONSEQUENCE OF):							1,		
2 Z	- Lung (oncer							1/X1		
ry, or other traumatic CERTIFICATION	Sequentially list conditions, if any, leading to immediate	ONSEQUENCE OF):							+ /		
Mar I	cause. Enter UNDERLYING	notaci	Garage						2 mo.		
힐프	CAUSE (Disease or Injury thet Initieted events DUE TO (OR AS A Co	ONSEQUENCE OF:	100								
티듀	resulting in death) LAST										
	d										
	PART II. Other eignificant conditions contributing to death but	not resulting in	the underlying	cause given in	Part 24a	WAS AN	umpey	245	WERE AUTOPSY FINDINGS		
any inju			the underlying	Cause green in	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	PERFORI		240.	AVAILABLE PRIOR TO		
40					1	YES 2	NO		COMPLETION OF CAUSE OF DEATH?		
shows					_				1 YES 2 NO		
60	DID TOBACCO USE CONTRIBUTE TO CAUSE OF	DEATH YES	NO D	UNCERTAIN	v 🗆 📗						
SICIAN	25. WAS CASE REFERRED TO MEDICAL 26.	PLACE OF DEATH	(Check only one)								
or item YSICI	EXAMINER? 1 YES 2 NO FIOSPITAL: 1 Inpetient 2 ER/Outpetie		OTHER:	X	a 🗆 an						
0 >	27. MANNER OF DEATH 28s. DATE OF INJURY	28b, TIME (OF 28c. INJL		6 Other (Spi						
	1 Natural 5 Pending (Month, Day, Year)	INJUE	TY WOI	RK?	26d. DEŞCRIE	E HUW IN	JUNY OCC	OHED			
B ag	2 Accident Investigation			ES 2 NO							
<u>∞</u> □	3 Suicide 8 Could not be 28e. PLACE OF INJURY — building, etc. (Specify)	At home, farm, stri	eet, factory, office		201. LOCATION City or Tox		nd Number	or Rural R	oute Number,		
28 TE	4 Homicide datermined					,					
Tel le	29a. CERTIFIER (Check only 1) CERTIFYING PHYSICIAN: To the best of my knowled	ice death occurred	of the time date	and place, and due	to the source(s)		حالفون				
IMPORTANT: If item O BE COMPLE	(Check only One) 2 MEDICAL EXAMINER: On the basis of examination a										
S		mazor investigation,	in my opinion, de	eth occured at the	1lme, date and	place, and	due to th	a cause(s)	and manner as stated.		
E m	296. SIGNATURE AND TITLE OF CENTIFIER	_		29c. LICENSE NUN	-		29d. DATE	SIGNED	(Month, Day, Year)		
E E	Un CUlturet ON			D2 43	356		▶ "	7/1	0/95		
일	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH	H (ITEM 27) (Type, P	rint)					/	1 1 he		
	WINCWATERFIELD MM	C4.	Long,	Hospifa	1 90	/	1.1	1	ANT		
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATU	UDE U	1714	1 100 174	10	-	4.	-10	orra		
	MIII 1 ·) 1995 July Studented		U								
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ID 21215-0020

BALTIMORE, MARYL

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be intained by TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be be filled within 72 hours after death with the State Dept. of Health and Memai Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	FOR STATE REGISTRAR	STATE OF MARYL		ENT OF HEALTH AND	MENTAL HYGIE					
	1. DECEDENT'S NAME (First, Middle, Last)	a.r.lr			2. DATE OF DEATH MONTH JULY 1	DAY 1	3. TIME OF DEATH			
				NOER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Forman			
	225-12-8582 x	EM 2 □ F	78 YRS. MON	THE DAYS HOURS MIN.	(Month, Day, Year) 3/4/17		Country) VA			
_	90. FACILITY NAME ! North Arune	del Hospital		CITY, TOWN OR LOCATION OF	DEATH	9c. COUNT	Y OF DEATH			
5	Anne Arundel Co	ounty Gen	eral	Glen Burnie	9	Ann	e Arundel			
EC	10a. STATE 10b. COUNTY		10c. CITY, TO	WN OR LOCATION			10d. INSIDE CITY			
DIRECTOR	Md. A.	A. Co	Se	everna Pk			LIMITS?			
AL	10e. STREET AND NUMBER			101. ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?			
FUNERAL	85 Glenr	is Kd.		2114	+6	1	ISA			
J.	11. MARITAL STATUS 1 Never Married 2 Married	2. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DECENDENT OF HISPA If yes, specify Cuban, Maxic	ANIC ORIGIN? (Specify)	fes or No- 14	I. RACE — American Indian, Black, White, atc.			
BY	3 M. Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES	1 TES 2 NO Spec			specify: White			
E	(Specify only highest grade cor Elementary/Secondary (0-12)	rnpleted) College (1-4 or 5+)	(Give kind of work of life, Do NOT use reti	one during most of working ed.)		/	ini			
MAPLETED	12		L abo	rer) Shi	Pyar	d			
8	17. FATHER'S NAME (First, Middle, Last)	1 (1)		18. MOTHER'S N	AME (First, Middle, Maide	n Sumame)				
BE	Alber-	+ Clar		Ig	o hee		301			
2	19a. INFORMANT'S NAME (Type/Print)	Hall	196. MAILING ADD	RESS (Street and Number or Rural	hat !	. >				
	204. METHOD OF DISPOSITION		12908	W. 3rd St	. Wilming	ton De	2.19805			
	1 Surial 2 Cremation 3 Remove 4 Donation 6 Other (Specify)		PLACE AND DATE OF DIS etery, crematory or other pi	ace)	7/11/12	OCATION - CH	y or Town, State			
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE	Arbu	22. NAME AND ADDRESS OF F		alto.	1*10			
	k kmen A	Mact	5				Funeral Home			
\dashv	23. PART/I. Enter the diseases, or con	iplications that caused	the death. Do not a	1701 Laure	ns st. B	alto.	MD 21217			
	Mock, or heart feliure. Lia	t only one ceuse on e	nch iine.	nor the mode of dying, ac-	on as cardiac or rea	piratory arres	intarval Between Onset and Death			
- 1	disease or condition resulting in death)	Coranan	Ischemi.	HEART DUE	KATT DI come					
	resolding in death) . a	Directions.								
Z	Sequentially list conditions, b	Carelmana		nes			Zuaron			
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (QR AS A	CONSEQUENCE QF):							
HC	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OFI:							
FE	resulting in death) LAST	125-2-4-1								
	PART II Other significant conditions of									
SAL	PART II. Other aignificant conditions of	contributing to death b	ut not reaulting in the	underlying ceuse given in	Part I. 24a. WAS A	N AUTOPSY DRMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO			
MEDIC					1 □ YES	2 🙀 NO	COMPLETION OF CAUSE OF DEATH?			
Σ	DID TOBACCO USE CONTRIB	LITE TO CAUSE O	E DEATH VEC F	TAIO CI HAICEBTAI			1 TES 2 NO			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH (C)		ППИ		* 4			
Sic		OSPITAL:	ОТ	HER: Nursing Home 5 ☐ Residence	6 C Oh (0					
ξ	27. MANNER OF DEATH	26a. DATE OF INJURY	26b. TIME OF	26c. INJURY AT	28d. DESCRIBE HOW	INJURY OCCUP	RED			
BY F	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	WORK?						
- 8	3 Suicide 6 Could not be	26a. PLACE OF INJURY building, atc. (Spec	— At home, farm, street,	factory, office	261. LOCATION (Stree City or Town, State	t and Number or	Rural Route Number,			
	4 Homicide determined					-,				
COMPLETED				he time, data and place, and du						
S I	2 MEDICAL EXAMINER: (On the basis of axamination	and/or investigation, in	my opinion, death occured at the	time, data and place, a	and due to the c	ause(s) and manner as stated.			
BE	296. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NU		29d. DATE S	IGNED (Month, Day, Year)			
2	30. NAME AND ADDRESS/OF PERSON WHO/C	OMBI EYED ONICE OF F	Tu armi	143266	69	1 7/	11/8			
1	1600 CAAN HO	MPLETED CAUSE OF DE	(I EM 27) (Type, Print)	0 21061	Paul J.	Vanna	Human			
.11				U1 6 4 4 0 1	TOTAL ATA	THUNDO	179 57 8703 67 669			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	TURE D		1441	754119	11977.007			

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DIVISION OF VITAL RECORDS

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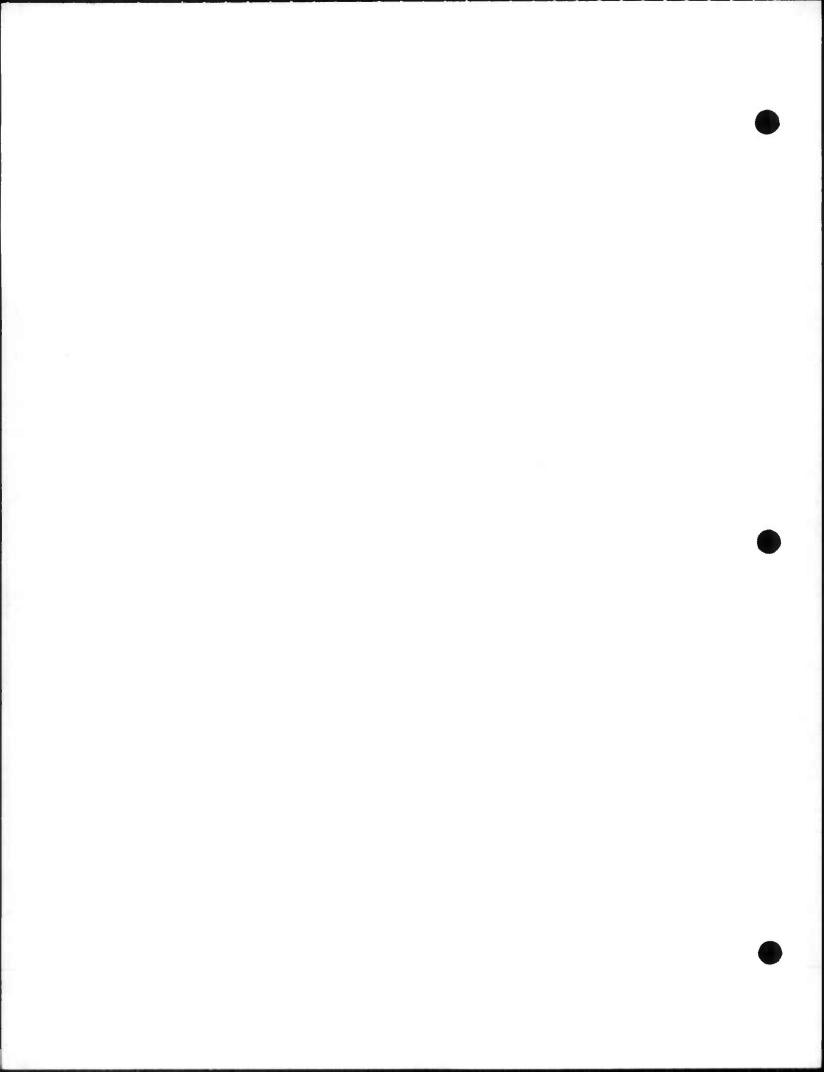
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

: retained by the hospital or attending physician. 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should TO HE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be detached that the funeral director, page 5 should be detached that the state death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

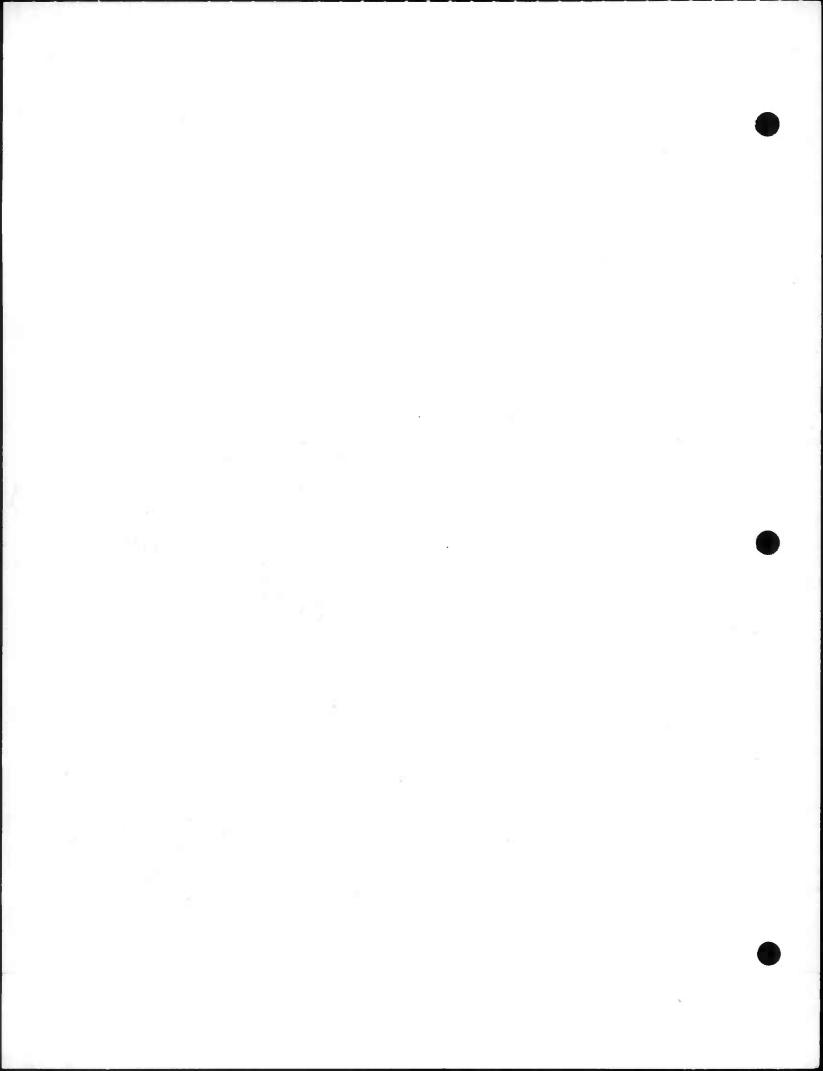
TO BE COMPLETED BY FUNERAL DIRECTOR

FOR STATE REGISTRAR	STATE OF MARYL		MENT OF I		MENTAL HYGIEI					
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			IME OF DEATH	н	
LILLIAN ELI	2ABETH !	COLLINS		-,-	JULY		YEAR	3-30	Am	
		In yrs. last birthday) _	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Dey, Year) Apr 9, 19	10	Mary	E (State or Form	nign	
9a. FACILITY NAME (If not institution, give stre	et and number)		9b. CITY, TOWN	TY, TOWN OR LOCATION OF DEATH Bc. COUNTY OF DEATH						
Saint Agnes Hosp	oital		Balti	more City	,	N	A			
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		I too CITY	TOWN OR LOCA	7.01						
Maryland NA			Baltimo				10d. INSIDE CI LIMITS? 1 X YES 2 [
100. STREET AND NUMBER 2521 James Stre	et		10	f. ZIP CODE 21230)	USA	COUNTRY?			
	2. WAS DECEDENT EVER IN			IC ORIGIN? (Specify Ve	e or No- 1	4. RACE — A	merican Indian	n,		
1 Never Married 2 Married 3XX Widowed 4 Divorced	FORCES? 1 YES			ecify Cuban, Maxican 2 X NO Specify			Black, Wh Specify:	White		
15. DECEDENT'S EDUCA (Specify only highest grade or	TION	16a. DECEDENT'S U	SUAL OCCUPATI	ON	16b. KIND OF BU	JSINESS/INDUS		MITT CC	-	
Elementary/Secondary (0-12)	College (1-4 or 5+)		ork done during mo retired.)	ost or working						
6		Homemal	ker		House	wife a	nd Mo	ther		
17. FATNER'S NAME (First, Middle, Last) John	Cunnan				ME (First, Middle, Maider					
	Curran		<u>-</u>		Elizabet					
19a. INFORMANT'S NAME (Type/Print) Mr. George A. Camp	hell				Linthicu			0		
20a. METHOD OF DISPOSITION		PLACEANDDATEO							-	
1X Buriel 2 Cremation 3 Remov	of from State cere	elery, crematory or oth	er place)	neterv 7/	10/95 Cr	OWNSVI	ly or Town, S	Marvla	nd	
21, SIGNATORE OF FUHERAL SERVICE LIGHT	SEE Kevin E.	Ecker	22. NAME A	ND ADDRESS OF FAC	YTLIK			iui y i u	iiu i	
* X. (/			McCu	lly Funer	al Home o	f Broo	klyn			
23. PART f. Enter the diseases, or con	applications that caused	the deeth. Do no	23/	Pataps	co Ave.	Balto.	Md.	21225 Approximat		
shock, or heart fallure. Lis	it only one cause on e	ch ilne.		da or dying, addr	se cardiac or rasp	matory stres	,,	interval Bet	tween	
iMMEDIATE CAUSE (Final disease or condition	SEP	212					- 1	Onset and	Death	
resulting in death) a.		CONSEQUENCE OF)	:					7100	7	
C h	Extens	ve De	cu bêtu	s Ulce	15		į	3 mil	tus	
If any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF)								
CAUSE (Disesse or Injury										
that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF)	:							
d.							i		-	
PART ii. Other aignificent conditions	contributing to deeth be	at not resulting in	the underlyln	g ceuse given in i	Part i. 24s. WAS AP			E AUTOPSY FINE		
					1 D YES		COM	LABLE PRIOR TO PLETION OF CA DEATH?		
					_ 1	,	0.000	YES 2 X NO	,	
DID TOBACCO USE CONTRI				UNCERTAIN				,		
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IQSPITAL:	28. PLACE OF DEATH	(Check only one)							
1 VES 2 X NO 1	Inpatient 2 ER/Outpo	itlent 3 DOA	Nursing Hom	e 5 🗆 Realdence						
1 SONatural 5 Pending	(Month, Day, Year)	28b. TIME	RY WO	RK?	28d. DESCRIBE NOW	INJURY OCCUI	RED			
2 Accident Investigation 3 Suicida 8 Could not be 28s. PLACE OF INJURY — At home, tarm, street, factory, office 28s. LOCATION (Street and Number or Rural Route Number)										
4 Nomicide 8 Could not be determined	building, atc. (Speci	fy)		·	City or Town, State)	nurar noute i	varnour,		
29a. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the beat of my knowle	edge, death occurred	at the time date	and place, and due	to the council and	nner en et-t- 1			\dashv	
(Check only one) 2 MEDICAL EXAMINER:								manner as sta	ted.	
296. SIGNATURE AND TITLE OF CENTIFIER,				29c, LICENSE NUM		29d. DATE S				
alluhamol		2-	44789	► JU			195			
30. NAME AND ADDRESS OF PERSON WHO	OMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, F	Print)		17/1					
KHIN MOUNTA U,	Dept hed	remis 8	f. Agua	olhop, 9	00 Caton	Ave,	Baltin	in pu	12/24	
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA		0						\neg	



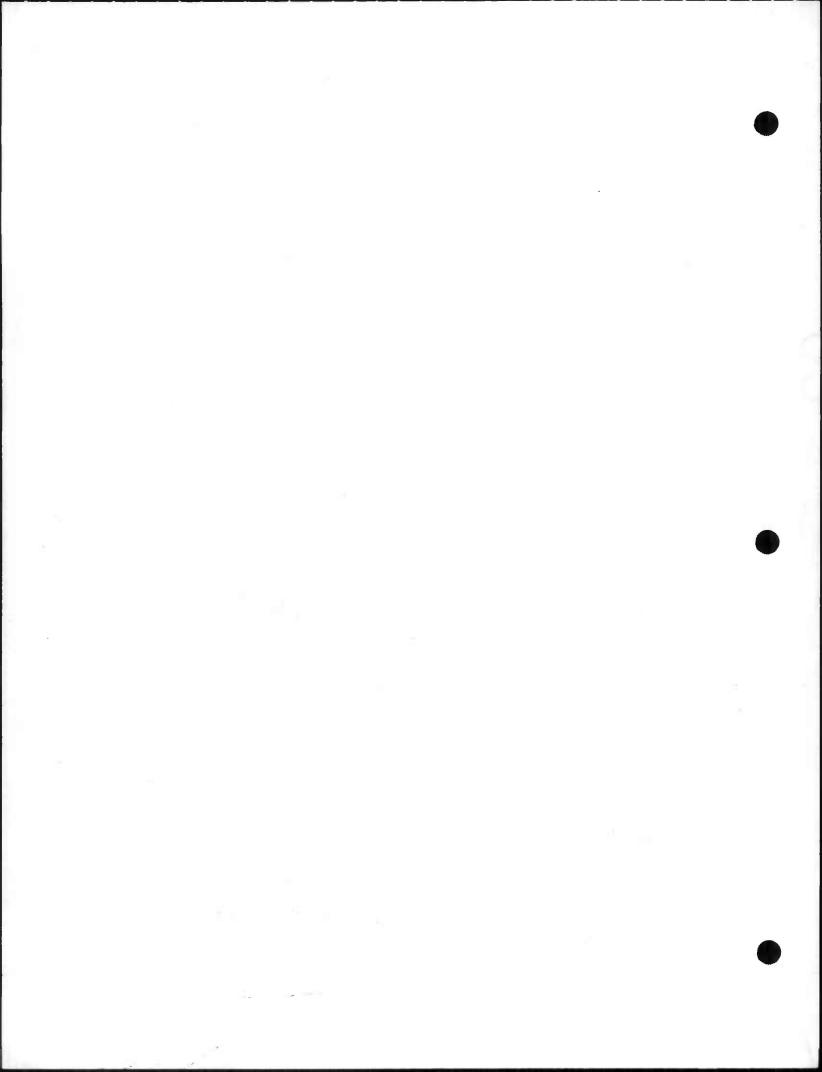
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_		FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPA	RTMENT OF H	EALTH AND ME DEATH	NTAL HYGIENE REG. NO.		
		1. DECEDENT'S NAME (First, Middle, MI CHAEL	Lest)		СНОЕ		DATE OF DEATH DAY JULY 9, 1	1995	3. TIME OF DEATH 10:15A M
Pi		4. SOCIAL SECURITY NUMBER 5. SEX 215-43-1406 1 X M 2 F 9. FACILITY NAME (If not institution, give street and number)			MONTHS DAYS	HOURS MIN.	DATE OF BIRTH (Month, Day, Year) DV 21, 199	HPLACE (State or Foreign try)	
1. 2, 3 should	СТОВ		HOPKINS HOSPITA	IMORE CITY	ATH 9c. COUNTY OF DEATH				
permit. Pages 1	DIREC	10e. STATE 10b. CC	oward		TY, TOWN OR LOCAT				10d. INSIDE CITY UMITS? 1 YES 2 K NO
. E	FUNERAL	8639 Wheatfield				21043		10g. CITIZEN OF USA	WHAT COUNTRY?
s the burial-transit	B	11. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 Tyes IF YES, GIVE WAR OR D	N U.S. ARMED 2 X NO ATES		ENDENT OF HISPANIC Cooling Cuban, Maxican, Po 2 NO Specify:		Biac	E — American Indian, sk, White, atc.
ed in by the funeral director, page 5 should be detached for use as the burial-tran or removal. medical examiner must be notified at once.	COMPLETED	15. DECEDENT'S (Specify only highest Elementary/Secondary (0-12)	EDUCATION grade completed) Cotlege (1-4 or 5+) NONE	16a. DECEDENT'S (Give kind of life. Do NOT t		ON st of working	16b, KIND OF BUSIN	IESS/INDUSTRY	
id be detached d at once,	BE CON	17. FATHER'S NAME (First, Middle, Las Chul Ho Choe	υ			18. MOTHER'S NAME (Mee Kyung	First, Middle, Maiden Su J Ju	imeme)	
be notified	10	190. INFORMANT'S NAME (Type/Print) Chul Ho Choe	(Father)	8639	Wheatfie	nd Number or Rural Route ld Way, El	licott Ci	ty, MD	21043
director, pa		20a, METHOD OF DISPOSITION 1 N Buriel 2 Cremetion 3 4 Donetion 5 Other (Specify) 21. BIOMATURE OF FUNEBAL SERVICE	Cr	PLACE AND DATE Setery, cremetory or Cestlawn	of DISPOSITION (Ne.	dens 11,1	995 Marr	TION — CHY OF T	
the funeral director, page yval, all examiner must be		* There	man it	Le	Leroy	& Russell Twin Knoll	Witzke Fu	neral H umbia,	Iome MD 21045
n and completely filled in by the to burial; cremation, or removal imatic event, the medical		23. PART I. Ener the diseases ahock, or heart fall iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially lifet conditions, if any, leading to immediate	aDUE TO (OR AS A	the death, DD ach line.	npt enter the mod	da of dying, auch as	cardiac or respirat	CME	Approximata interval Between Onset and Death 22hsur S
ending physicia I Hygiene prior or other trau	CERTIFICATION	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	G	CONSEQUENCE C		C. APP	RUVL		
in Me	MEDICAL (PART II. Other algnificent cond		ut not resulting	in the undarlying	cause given in Pari	1 . 24a. WAS AN AU PERFORME	ED?	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
scate has bee State Dept. or	¥.	25. WAS CASE REFERRED TO MEDIC/ EXAMINER?	HOSPITAL:	26. PLACE OF DEA	OTHER:				4
TOR: After this certification after death with the 28 1s marked, or	TED BY PHYSICI	1 Ves 2 No 1 Tripetient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Realdence 8 Other (Specify) 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 5 Could not be building, atc. (Specify) 28. DATE OF INJURY 28b. TIME OF INJURY AT WORK? 1 Ves 2 No Mortin Benedicine 8 Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED INJURY AT WORK? 1 Ves 2 No Mortin Benedicine 8 Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED INJURY AT WORK? 1 Ves 2 No Mortin Benedicine 8 Other (Specify)							
	COMPLET		HYSICIAN: To the best of my know	ledge, death occum					
PORT P	TO BE (29b. SIGNATURE AND TITLE OF CENT	((d)			29c. LICENSE NUMBER	2	DATE SIGNED	(Month, Day, Year)
		30. NAME AND ADDRESS OF PERSON (E TV 31. DATE FILED (Month, Day, Year)	Kocis, MO	600	North	walk st	reet Bult	more i	40
		JUI 1 2 1995	July Devoleon Ran						



1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

			TIEGIOTTIATI				OLITI	FICAL		DLA	111		HEG. NO.			
			1. DECEDENT'S NAME (First	, Middle, Last)						2. DATE (2. DATE OF DEATH SONTH DAY YEAR 3. TIME OF DEATH			3. TIME OF DEATH		
	- 1		HANNAH					CHOE							7:30P M	
			4. SOCIAL SECURITY NUM		5. SEX	8. AGE (1)	n yrs. last birthde		R 1 YEAR	IF UNDER		7. DATE C	Dev Year		8. BIRTHP Country)	LACE (State or Foreign
	9		216-39-3512		1 🗆 M 2 🗶 F		2 YRS	MONTHS	DAYS	HOURS	MIN.	June	20, 1	993	Goothey)	MD
	3 should		9a. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CIT	Y, TOWN	OR LOCATI	ON OF DE	EATH		9c. COUNT	TY OF DE	ATH
	2, 3	ECTOR	THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY N/A								A					
	I	5	RESIDENCE OF DEC								21/					
	Pages	DIRE	10a. STATE 10b. COUNTY MD HOWALT				10c. (TY, TOWN			3.7					IOd. INSIDE CITY LIMITS?
	permit.												YES 2 NO			
		RAL	10s. STREET AND NUMBER		101. ZIP CODE 21043							IAT COUNTRY?				
E.	burial-transit	Ä	8639 Wheatf	ieid M						210	143			US	iΑ	
020 physician.	riaf-t	FUNE	11. MARITAL STATUS 1 X Never Married 2		12. WAS DECEDEN	T EVER IN	U.S. ARMED	ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— 1/4 NO If yea, specify Cuban, Maxican, Puarto Rican, atc.)					4. RACE -	– American Indian, White, atc.		
21215-0020 I or attending physic	the bu	ВУ	3 Widowed 4 Divo		IF YES, GIVE Y				1 YES 2 X NO Specify:							Korean
215-00 attending	S	ED														Notean
12 m	Re	ETE	(Specify onl	y highest grade	completed)		(Give kind	'S USUAL (of work done use retired.)	during me	ON ost of working	ng	16b.	KIND OF BUS	INESS/INDU	STRY	
	of for		Elementary/Secondary (f	1-12)	None	+)	N/A						N/	7		
ND	detached once.	COMPL	17. FATHER'S NAME (First, M	that the state of	NOME		IN/ E	·		_						
		-	Chul Ho	Choe									iddle, Maiden	Surname)		
# 8 E		H										ing Ji				
E, MARY y be retained to sage 5 should be notified	sho	2	19a. INFORMANT'S NAME (ather)								er, City or Town			21042
	30e 5	_					8635	wnea	ILLIE	STG M	ay,	EIII	cott C	ity,	שואו	21043
6 may	must i		20a, METHOD OF DISPOSIT		oval from State	20b.	PLACE AND DAT	E OF DISPO	SITION/N	ame of	Jul	Y DATE		CATION — CI		•
ALTIMOR death. Page 6 ma			4 Donation 5 Other			_ Cr	estlaw				11,	1995	Mar	riott	svil	le, MD
ALTIM death. Page	tuneral di i. examiner		21. SIGNATURE OF SUMMER	L SERVICE LIC	ENSEE	1-	P			& RIT			tzke F	hnera	al Ho	me
			Ves	secal	2m)_	XX	0	159	555 ?	Twin	Knol	lls R	d. Col	umbia	, ME	21045
hours after	d in by the or removal. medical e		22 BADT I Sider the diseases or considerations.													
5	filled in on, or r		ahock, or h IMMEDIATE CAUSE (Fir	eert fellure.	List only on the	ise on ea	ch line.							- NA	ND	Interval Between Onset and Death
22	× 20 00		disease or condition	iai		1	RRAIN	DE	a.sn/	1			92W	My.	0011	+3 hours
with 50	ompletel d. crema event,		resulting in death)		DUE TO	(OR AS A	CONSEQUENCE	OF):	111		-	mil	WA	7:3	UI.	- nour
executed	0 10	2				MATE	n 1/ela	11/0	A:	1.00 4 1	HA	200	$O(N_f)$	200		Ì
S 50	to bur	CERTIFICATION	Sequentially list condit if any, leading to imme		DUE TO	(OR AS A	CONSEQUENCE	OF):	TCC	NOE ~	7	Ah.	Mr.			
S S	prior tra	₹	cause. Enter UNDERLY	ING	•					n	(:-1	11				
.O. By	the ph		CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):													
	Hyd e	E	resulting in death) LAS	T ,	d											
DS, P	d Mental		PART II. Other aignifics	nt condition	a contribution to	double bu		to at a				- · · · T			_	
m m	A and	EDICAL	Shock						nderiyin	g cause g	given in	Part I.	24s. WAS AN / PERFORI		, A	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO
Lines #	signed by Health an	ă	SNOCI	1	spinal (ous	intra	4				_	1 YES 2	NO		OMPLETION OF CAUSE OF DEATH?
11 '3	5 5 5	≥										_		,	1	TYES 2 HO
- ×	has been Dept. of n 23 sho	ä	DID TOBACCO U		RIBUTE TO CA					- UNC	ERTAIN	4 🗆				, -
_	State D	PHYSICIAN:	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL	HOSPITAL:	2	6. PLACE OF D	OTHE								
PHYSICIAN:	the State	YSI	1 TYES 2 NO		1 Inpatient 2		tlent 3 DOA			e 5 🗆 Re	sidenca	8 🗆 Other	(Specify)			
2 5	with t	표	27. MANNER OF DEATH		28a. DATE OF (Month, D			ME OF	28c. INJ WC	URY AT		28d. DESC	CRIBE HOW IN	JURY OCCU	RED	
	After this death with	BY		Pending Investigation	July	8,199	7 100		1 🗆 '	тт	100	MOT	on Vel	nick	Acc	crent
	4 0 m			Could not be	28a. PLAČE C building,	F INJURY - alc. (Specif	At home, fern	, street, fac	tory, offic				TION (Street at Town, State)	nd Number or	r Rural Rou	ite Number,
DR ATTENDING	DIRECTOR: hours after Item 28 Is	ETE	4 Homicide	determined			Staff	T					Olum	300 A	1m	(Ans)
		3	29a. CERTIFIER (Check only	IFYING PHYSIC	CIAN: To the best of	my knowle	dge, death occi	rred at the	time, date	and place,	end due	to the ceus	e(s) and man	ner as atated	1.	
THE HOSPITAL	FUNERAL within 72 TANT: If	COMPLET														ind manner as stated.
오	HA WEE	O I	296. SIGNATURE AND THE	OF CERTIFIER						29c, LICE	NSE NUM	/BER		29d DATE	SIGNED /A	forith, Day, Year)
王	TO THE FUNER be filed within 7 IMPORTANT:	0	140	D	1/1/-	>				T	745	878	_	▶ Tu	1. 9	1961
	- 0 =	2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAU	SE OF DEA	TH (ITEM 27) (7)	oe, Print)			13	0 00		74	4 1	, , , , , ,
	-	:	Krinh	C.	Kocis	1-		m/s	10/14	G St	oot	1.1	trans.	5 M	د ما	1167
		j	31. DATE FILED (Month, Day,	Year)		R'S SIGNA	TURE	100	100 17	/-		LG	11000	011	7 0	100/
			JUL 1 2 19	95 A	32 REGISTRA	rtand	all									



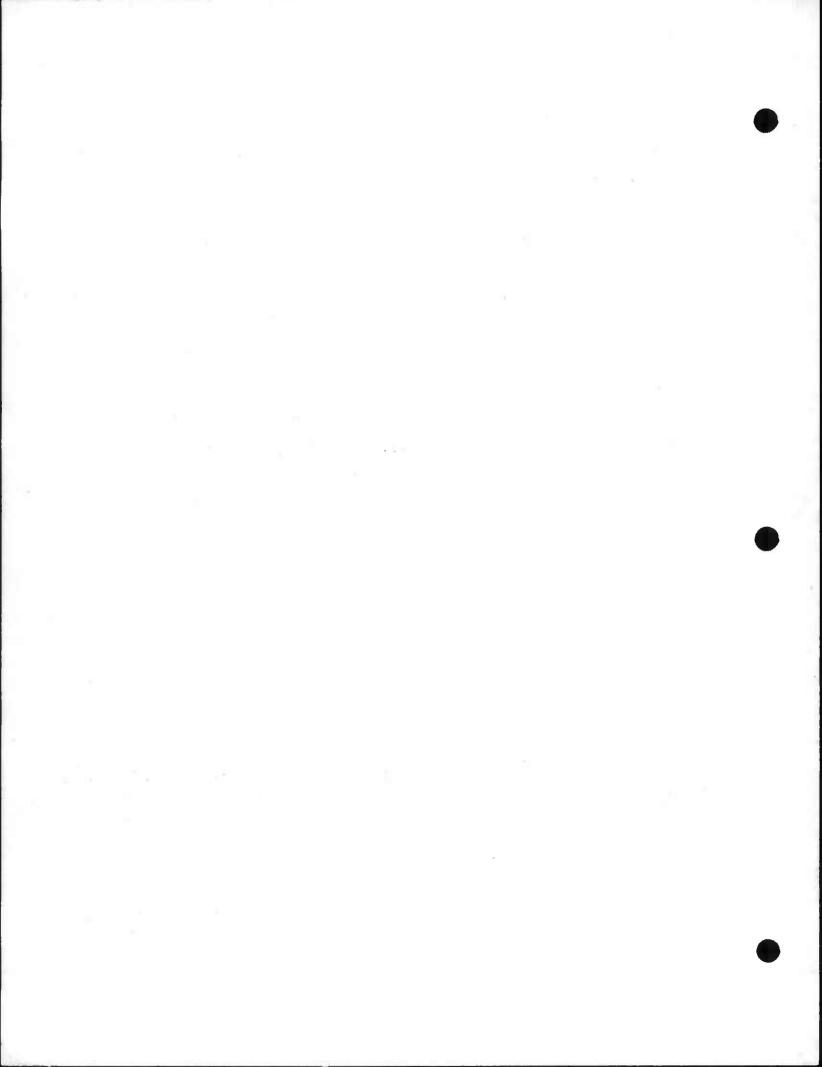
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1	-	FOR STATE REGISTRAR
	1. [ECEDENT'S NA

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	CERTIFIC	CATE OF DEATH	REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH		3. TIME OF OEATN					
	SAMUEL EGGERSTON Jr.			MONTH DAY	YEAR						
		AGE (In yrs. last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.	JULY 01 1	995	2:20A M					
	214-78-8699 10-120F	-	ONTHS DAYS HOURS MIN.	/- 21-69	8. BIRTH Countr	HPLACE (State or Foreign N) MD					
OR	9a. FACILITY NAME (If not institution, give street and number) UNION MEMORIAL HOSPITA	L.	Baltimore C		COUNTY OF D	DEATH A					
5	RESIDENCE OF DECEDENT										
DIRECTOR	MD 106. COUNTY	1 '	TOWN OR LOCATION BALT		10d. INSIDE CITY LIMITED						
FUNERAL	1246 LINDEN LEAF CT		10f. ZIP CODE 2/202	109	CITIZEN OF V	WHAT COUNTRY?					
3	11. MARITAL STATUS 12. WAS DECEDENT EV	/ER IN U.S. ARMED	13. WAS DECENOENT OF HISPAN	IC OBIGINZ (Specify Year or N	-	E — American Indian,					
BY FI	1 Never Merried 2 Merried FORCES? 1 IF YES, GIVE WAR	YES 2 PNO	If yes, specify Cuban, Mexicar 1 YES 2 A NO Specify	, Puerto Rican, etc.)	Biaci	Hy: Black					
	15. OECEDENT'S EOUCATION (Specify only highest grade completed)	16e, OECEDENT'S US	BUAL OCCUPATION rk done during most of working retired.)	16b. KIND OF BUSINES							
BE COMPLETED	Elementage@eandary (0-12) Coflege (1-4 or 5 +)	LA60,		JAVITOR	LIAL						
$ar{o}$	17. FATHER'S NAME (First, Middle, Last)			AE (First, Middle, Maiden Surna							
m m	SAMUEL EGGERSTON, SA	2	BRENO	A CLARIT	D						
0	19e, INFORMANT'S NAME (Type/Print)		DDRESS (Street end Number or Rural R								
F	KATRINA DAVIS	1246 4	INDELEAF OF	T BALT MD	212	02					
	20e. METNOD OF DISPOSITION	20b. PLACE AND DATE OF	DISPOSITION (Name of	DATE 20c. LOCATIO	N — City or To						
	1 Buriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)	cometery, crematory of other	MEM. PARK.	7/7/5 BALT	mD						
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACE								
	Kalling R.T.		BETTS FUNE	ERAL HOM	£						
1	23. PART i. Enter the diseases, or complications that ca	upped the death. Do not	1129 N. CARO.	LINE ST BA	LTM						
	ahock, or heart failure. List only one cause	on each line.	enter the mode of dying, such	as cardiec or respirator	y arrest,	Approximata interval Batween					
	IMMEDIATE CAUSE (Final disease or condition	1/11	bund of Cl	1		Onset and Death					
	resulting in death)	- 4 4	ound of 4	esl							
	DUE TO (OR	AS A CONSEQUENCE OF):									
Z	Sequentially list conditions,										
ĔI	If any, leading to immediate	AS A CONSEQUENCE OF):									
RTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury										
	that initiated events resulting in death) LAST	AS A CONSEQUENCE OF):									
5	d										
	PART ii. Other algnificant conditions contributing to dee	th but not resulting in	the underlying ceuse given in F	Part I. 24s. WAS AN AUTO	PSY 24h	WERE AUTOPSY FINDINGS					
8		2		PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE					
				— TYES 2 □ N	•	OF DEATH?					
Z.	DID TORACCO LISE CONTRIBUTE TO CALL	F OF DEATH AND	Пиоп			YES 2 NO					
AN	DID TOBACCO USE CONTRIBUTE TO CAUS										
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	26. PLACE OF OEATN	(Check only one)								
1 S	1 ♠ YES 2 □ NO 1 □ Inpatient 2 □ ER	/Outpatient 3 DOA 4	☐ Nursing Nome 5 ☐ Residence 6	Other (Specify)							
	27. MANNER OF DEATH 1 Netural 5 Pending	INJUR	Y WORK?	28d. DESCRIBE NOW INJURY	OOCURED	14					
à	2 Accident Investigation	0150	M 1 YES 2 NO	subje	5	red					
	building, etc.	JURY — At home, farm, stre (Specify)	et, tactory, offica	281. LOCATION (Street and Nu	imber or Rural R	loute Number,					
3	4 Homicide determined	CTKES	=7	SUO BIK FO.	setti1	1em					
준	29e. CERTIFIER 1 CERTIFYING PNYSICIAM: To the best of my I	knowledge, death occurred	at the time, date end place, end due t	o the cause(s) and menner e	a stated.						
COMPLETED	2 MEDICAL EXAMINER: On the basis of exemit) end menner ee stated.					
_ 11	294 SIGNATURE AND TITLE OF CERTIFIER		29c, LICENSE NUMI			(Month, Day, Year)					
4	1 and only	A(A(A))	O.C.M		JULY 0						
2	ME AND ADDRESS OF PERSON WIND COMPLETED CAUSE OF	F DEATH (ITEM 27) (Type, Pri			,011 0	1 1 1 2 2 3					
	J. LAPON LOCKE, MDI	11 Penn S	treet, Baltin	nore, Mary	Land 2	21201.					
	JUL 1 2 1995 Julia JUSTIAN	NON-TIME			<u>.</u>						
100											



3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

Specify: WHITE

1 X YES 2 | NO

21286

Interval Between

Onset and Death

Approximata

24b. WERE AUTOPSY FINDINGS

MARYLAND

9c. COUNTY OF DEATH

USA

BALTIMORE

10g. CITIZEN OF WHAT COUNTRY?

9:43 PMH

should

permit. Pages 1, 2, 3

for use as the burial-transit

director, page 5 should be detached

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CERTIFICATION

MEDICAL

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after de	TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and completely filled in by the fi	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical ex
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH LUCILLE BERNICE **EVANS** Tuly 4. SOCIAL SECURITY NUMBER 6. AGE (in yrs. last birthday) S. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH DAYS 1 M 2 XF 214-18-4724 5/10/23 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH STELLA MARIS HOSPICE TOWSON RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND N/A BALTIMORE CITY 10e. STREET AND NUMBER 10f. ZIP CODE 1412 WALKER AVENUE 21239-1705 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 XMarried 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) 12th GRADE ACCOUNTANT MARTIN MARIETTA 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) CLARENCE K. TANNER GERTRUDE TRENCH 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD D. EVANS 1412 WALKER AVE. BALTIMORE, MD 21239 20a. METHOD OF DISPOSITION

1 X Burlel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata DATE PARKWOOD CEMETERY 7/11/95 BALTIMORE 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 23, PART I. Enter the diseases, or complications that caused the desth. Do not enter tha mode of dying, such as cardiac or respiratory arrest, ahock, or heart fallure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition VARIANCANCER resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentielly list conditions, DUE TO JOR AS A CONSEQUENCE OF if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY

DID TOBACCO USE CONT	RIBUTE TO CAUSE OF DEATH	YES NO VI UNCERTAI	1 U YES 2 NO	COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF	F DEATH (Check only one)					
1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 C	OTHER: 4 Nursing Home 5 Residence	eX Other (Specify) HOSPICE.				
27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	b. TIME OF 100 28c. INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCCURED				
3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF INJURY — At home, building, etc. (Specify)	term, atreet, factory, office	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER CERTIFYING PHYS	ICIAN: To the beat of my knowledge, death o	occurred at the time, data and place, and du	a to the cause(a) and menner as stated.				

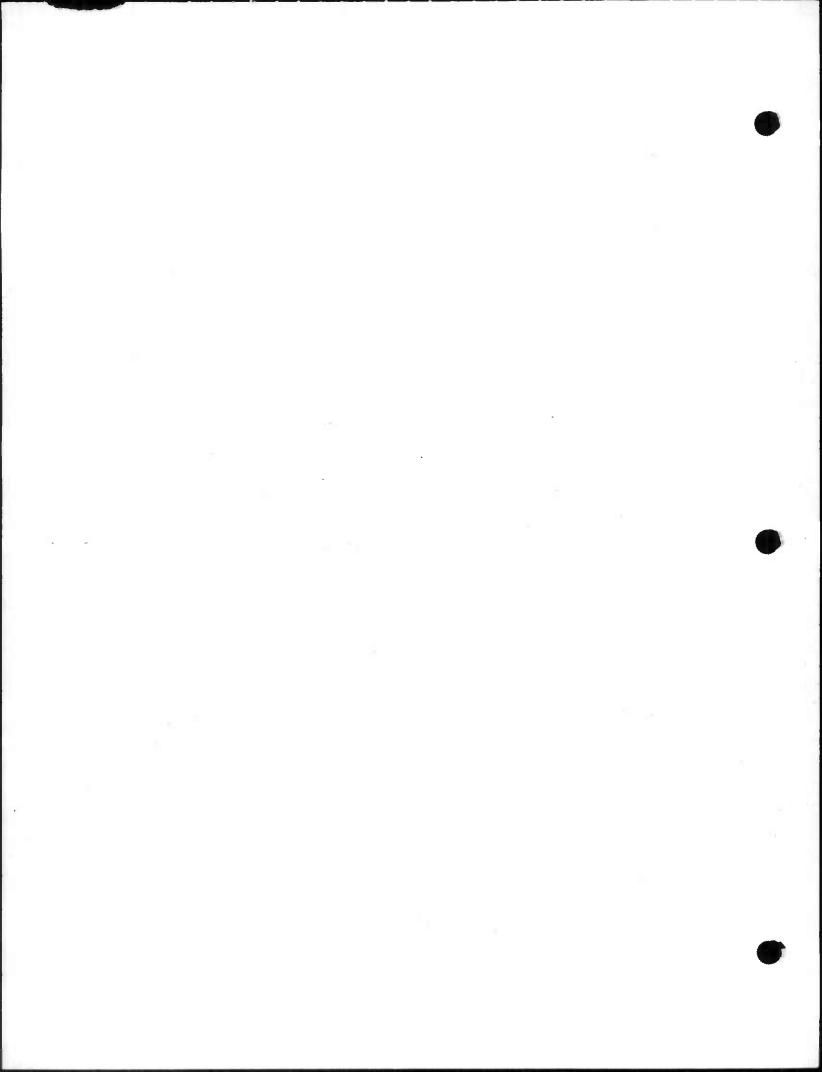
(Check only	CERTIFYING PHYSIC AN: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(a) and menner as stated.
one)	MEDICAL FYAMINED: On the hoole of everylection and/or investigation in

70010	29d. DATE SIGNED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204

JAMES TO DULANE



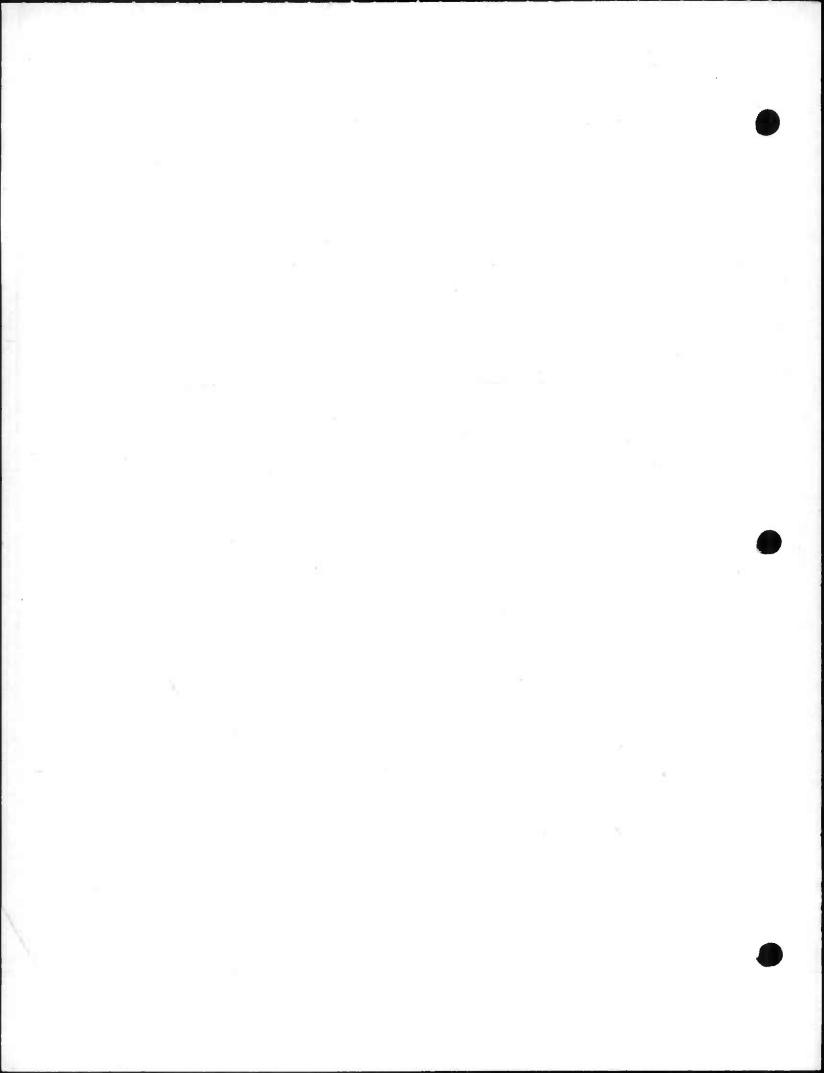
DIVISION OF VITAL RECORDS, P.O. BOX 68760	BALTIMORE, MARYLAND 1215-0020	LAMB 212 5-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with: 724 hours after death. Page 6 may be intra-	ours after death. Page 6 may be retained	The Miles of artended physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be described by the attending physician and completely filled in by the funeral director, page 5 should be filled within 72 hours after death with the State Dest. of Health and Mental Hydiene prior to burial, cremation, or removal.	I in by the funeral director, page 5 should be removal.	detached for up as the burial-transit
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	nedical examiner must be notified	t once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

permit. Pages 1, 2, 3 should

FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH

	1. DECEDENT'S NAME (First,		Felter							2. DATE OF	DEATH D		YEAR	3. TIME OF DEATH	
					nes Bal					July	5, 1	995		10:58 P.	
	4. SOCIAL SECURITY NUMB		5. SEX	8. AGE (In yrs.		IF UNDE	DAYS	HOURS	24 HRS. MIN.	7. DATE OF (Month, E	BIRTH Pay, Year)		8. BIRTH Countr	IPLACE (State or Fore	ign
	220-09-081 Page 11 not in		1 M 2 F	86	YRS.		1			Oct.	8, 1			nington,	D.C
OR			96. CITY, TOWN OR LOCATION OF DEATH COCKEYSVILLE BALTIMO												
티	RESIDENCE OF DEC	1 45 . 617	10c CITY TOWN OR LOCATION												
DIRECTOR	MD		COCKEYSVILLE						10d. INSIDE CITY LIMITS? 1 YES 2 N	0					
FUNERAL	100. STREET AND NUMBER		101. ZIP CODE 21030						10g. CITIZEN OF WHAT COUNTRY? USA						
5	11. MARITAL STATUS		12 WAS DECEDEN FORCES? 1	T EVER IN U.S.	ARMED	13.	WAS DE	ENDENT O	F HISPA	NIC ORIGIN? (Specify Yes	or No-	14. RACE	- American Indien,	
BY	1 Never Married 2 3 Widowed 4 Divo		IF YES, GIVE W	MR OR DATES	440		1 TYPE, SE	2 NO	n, Mexica Specif	nn, Puerto Rici y:	en, etc.)		Speci		
	15. DEC (Specify only	EDENT'S EDUC highest grade	CATION completed)	16a.	DECEDENT'S	USUAL O	CCUPATI	ON of working	va	16b, K	ND OF BUS	SINESS/INI			
BE COMPLETED	Elementary/Secondary (0		College (1-4 or 5 +	·)	(Give kind of life. Do NOT u			Jat of Workin	·v		Roads	s Con	nmiss	ion	
OS	17. FATHER'S NAME (First, Mi		George Was		Felter		_	18. MOTE	HER'S NA	ME (First, Mid					
E'C			W. Felt	er-				C	athe	rine-	Rall	Ball			
2	19e. INFORMANT'S NAME (7)				19b. MAILING	ADDRES	\$ (Street	and Number	or Rural	Route Number,	City or Town	n, State, Zip	Code)		
	J.E.B. Fel				319	Broa	admo	or Ro	ad,	Balt	imore	e, MI	21	.212	
	20e. METHOD OF DISPOSITI 1 Burlal 24 Crematio 4 Donation 5 Other	ON n 3 □ Remo (Specify)	oval from State	cemetery,	cremetory or c	ther place)	1			997			City or To		
	21. SIGNATURE OF PUNERAL	21. SIGNATURE OF CHERAL SERVICE LICENSINE						ND ADDRES	SS OF FA	July	Lat	onsv	111e	, MD	
	· DC	Bryan	aw. Clar	gry	>	Lemmon Funeral Home of Du 10 W. Padonia Rd., Timoni									Inc
	23. PART I. Enter the di shock, or he IMMEDIATE CAUSE (Fin disease or condition resulting in death)	art fallure. I	. Aut	se on each l	Ina. ~								1	Approximate interval Batt Onest and E	ween
CERTIFICATION	Sequentially list condition in any, leading to immediate. Enter UNDERLY! CAUSE (Disease or injurthat initiated events resulting in death) LAST	sclerati Keart Disserie Sequence of: Congestinis Keart Failure SEQUENCE OF):													
- 11	PART ii. Othas algnifica	nt condition	contributing to	death but no	t resuiting	in the ur	nderlyln	g cause g	Ivan in	Part i. 24	a. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FIND	HNGS
MEDICAL	lys	of reading in the underlying cause given in Part					24s. WAS AN AUTOPSY PERFORMED?			AMILABLE PRIOR TO COMPLETION OF CAU DF DEATH?	JSE				
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	DID TOBACCO U	SE CONTR	IBUTE TO CA	USE OF DE	EATH YE	S 🔲	NO [UNC	ERTAII	N 🗆					
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26. PL	ACE OF DEA	OTHEI									
ΙΧ	1 TYES 2 NO		1 Inpetient 2			4 Nur		e 5 🗆 Re	sidence	6 🗆 Other (S	pecify)				
BY PH		Pending nvestigation	28e. DATE OF (Month, Da		28b. TIM	E OF URY M		URY AT PRK? YES 2	NO NO	28d. DESCR	BE HOW IN	JURY OC	CURED		
	3 Suicide 6 6	home, ferm,	street, fect	tory, offic	•		261. LOCATIO	LOCATION (Street and Number or Rural Route Number, City or Town, State)							
١٣	290. CERTIFIER 1 CERTI	FYING PHYSIC	CIAN: To the best of	my knowledge	death occurs	ed at the t	lime dete	and place	and due	An Oha named		2 N	72.		
COMPLETE	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) end menner ee stated. 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) end manner ee stated.												ed.		
BE (296 SIGNATURE AND TITLE	OF CENTIFIER	1,00	7				29c. LICE	NSE NUM	ABER		29d. DAT	E SIGNED	(Month, Day, Year)	
<u>و</u> ا	1/4	wing.	aroz					Do	26	0)		1	17/	155	
-	30. NAME AND ADDRESS OF Frank San			e of beath (1 46 Pap			oad.	Jack	cson	ville.	MD.	211	131		
	31. DATE FILED (Month, Day)			rs SIGNATURE	Rardall									-	\dashv



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OF VI	PHYSICIAN:
DIVISION OF VITAL RECORDS, P.O. BOX 68760	DSPITAL OR ATTENDING PHYSICIAN: TI
5	OR
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31. DATE FILED (Month)

32 REGISTRAN'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR **CERTIFICATE OF DEATH** REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1 99 July 2:20 Thomas **JEFFERSON** Ferguson, II AM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. E. BIRTHPLACE (State or Foreign HOURS DAYS 1 X M 2 - F 219-86-1115 32 YRS. Oct 8, Mary Land permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Maryland General Hospital Baltimore n/a 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland n/a Baltimore 1 X YES 2 | NO FUNERAL 10a STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? filled in by the funeral director, page 5 should be detached for use as the burial-transit 1218 West Lanvale Street 21217 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-if yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 X Never Married 2 Merried 1 TES 2 NO BY Specify: Specify: 3 Widowed 4 Divorced Bl.ack 15. DECEDENT'S EDUCATION COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) College 1 STock Clerk Maryland State once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 76 Thomas Fergusen THOMAS J. FERGUSON **BE** Barbara Johnson BARBARA C. notified 190. INFORMANT'S NAME (Type/Print) THOMAS J. FERGUSON 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 842 North Carey Street Thomas Forcuson Baltimore, MD 21217 Pe 20a. METHOO OF DISPOSITION
1 M Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must cometery, crematory or other place) Arbutus <u>Memorial Park</u> 4 Donation 5 Other (Specify) MD Baltimore County, examiner 21. SIGNATURE OFFUNERAL SERVICE SCENSEE 22. NAME AND AGORESS OF FACILITY Nutter Funeral Homes Inc. Dalyo Rollens 2501 Gwynns Falls Parkway Baltimore, Maryland medicai 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heart fellure. List only one ceuse on each line. interval Between 6 IMMEDIATE CAUSE (Final **Onset and Daath** completely filled rial, cremation, i the disease or condition resulting in death) Acquired Immune Deficiency Syndrome event, DUE TO (OR AS A CONSEQUENCE OF): and com o burial, o Pnumonia traumatic CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): prior to if any, leading to immediate cause. Enter UNDERLYING signed by the attending physician Health and Mental Hygiene prior to Sepsis other t CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 50 any injury. PART il. Other algnificent conditione contributing to deeth but not resulting in the underlying ceuse givan in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 TONO OF DEATH? 1 TYES 2 NO certificate has been in the State Dept. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 2 UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER. ☐Minpetient 2 ☐ ER/Outpetient 3 ☐ DOA 1 TES 2 X NO 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 5 27. MANNER OF DEATH 28e. DATE OF INJURY this c 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED is marked, 1 Natural 1 YES 2 NO ВУ death After 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. LOCATION (Street end Number or Rural Route Number, City or Town, Stete) COMPLETED 8 Could not be after DIRECTOR 28 4 Homicide hours item 29e. CERTIFIER 1X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(e) end manner ee stated. TO THE HOSPITAL OF THE FUNERAL DE FILED WITHIN 72 NO IMPORTANT: If Its 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE anter on call 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M.R. ZINDELHADID, M.D C10 Maryland General Hospital

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	7 6	FOR 1 - STATE		LAND / DEPARTME	NT OF HEALTH AN	D MENTAL	HYGIENE	
ı		REGISTRAR		CERTIFICA	TE OF DEATH		REG. NO.	
		1. DECEDENT'S NAME (First, Middle, Last)	CIDEE			2. DATE OF MONTH	DAY YE	3. TIME OF DEATH
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020 physician. burial-transit permit.	VERAL	100. STREET/AND NUMBER 4849 Oaklo	ind Av	e. Sout	101. FIP CODE	417	10g. CITIZEN	OF WHAT COUNTRY?
020 physician. burial-trar	FUN	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER I FORCES? 1 YES	2 V NO	13. WAS DECENDENT OF HIS If yee, specify Cuben, Mer	PANIC ORIGIN? (xican, Puerto Ric	Specify Yea or No — 14. an, atc.)	RACE — American Indian, Black, White, sta
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	COMPL	17. FATHER'S NAME (First, Middle, Last)	7. 1.		18. MOTHER'S	NAME (First, Mid	lle, Malden Surname)	211011
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LTIMO ath. Page 6 ineral directo		21. SIGNATURE OF FUNERAL SERVICE LEC	ENGEE DIY		22. NAME AND APDRESS OF	FACILITY	15 Dallo	nal Hanaa
0 - 0		► JAJebh	12. 9	USS !	Joseph L	North	Ave Bal	to. Md. 21216
in by remo		23. PART I, Enter the diseases, or of shock, or heart failure.	complications that ceuse List only one ceuse on a	d the death. Do not en	ter the mode of dying, a	uch as cardia	or respiratory arrest	Approximata interval Between
3 6 3 €		IMMEDIATE CAUSE (Final disease or condition	N met a mi a a a	a a contrata de la contrata del contrata de la contrata de la contrata del contrata de la contrata de la contrata de la contrata de la contrata de la contrata de la contrata de la contrata de la contra				Onset and Daath
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TAL RECORDS, P.O. BOX The law requires that the death certificate be ex the has been signed by the attending physician a see Dept. of Health and Memtal Hygiene prior to em 23 shows any injury, or other traum	MEDICAL C	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other significent condition: DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	DUE TO (OR AS A d	DEATH YES 28. PLACE OF DEATH (Che	NO UNCERTA	AIN D	PERFORMED? VES *XXNO ISPECTION	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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BALTIMORE, MARYLAND 21215-0020

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CERTIFICATION

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PURTAK

JYRVBIL

4940

DIRECTOR: /

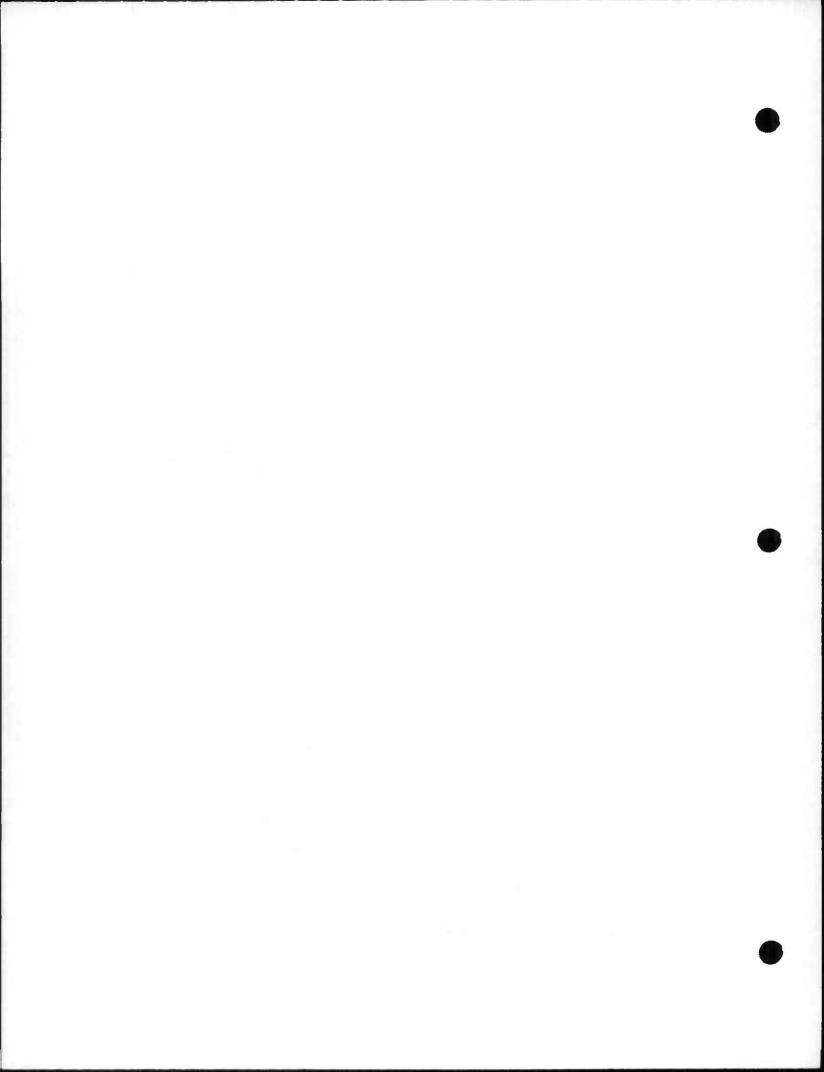
TO THE HOSPITAL D TO THE FUNERAL D Be filed within 72 ho IMPORTANT: If its HOSPITAL

item 28 Is ETED

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	DRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Ps nous after death with the State Debt. of Health and Mental Hydiene prior to burial, cremation, or removal.	
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DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fa nours after death with the State Dept. of Health and Mental Hydiene prior to burial, cremation, or removal.	tem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once,
ATTE	ECTO s	1 28
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ROSE ELLEN GRADY 4. SOCIAL SECURITY NUMSER 8 SEY 8. AGE (in yrs. lest birthday, IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. (Month, Day, Year) 1 M 2 F YRS. MARYLAND 43 Aug 217-52-9011 1951 9s. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 3700 N. ROGERS AVENUE BALTIMORE CITY N/A RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10b. COUNT 10d. INSIDE CITY N/A BALTIMORE CITY MARYLAND 1 X YES 2 | NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3700 N. ROGERS AVENUE 21207 S. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If was assected Euben. Mexican, Puerto Ricen, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, OIVE WAR OR DATES 14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Married
3 Wildowed 4 Divorced If yes, specify Cuben, Mexican, Puerto Ri 1 YES 2 (7) NO Specify: Specify: Specify: **BLACK** 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 8+) 12th grade HOUSEWIFE UNKNOWN 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surneme) WILLIAM W. RYCE ROSALEE RYCE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wesley Neal Grady 3700 N. Rogers Avenue, Baltimore, Maryland 21207 29a. METHOD OF DISPOSITION
1 △ Burlel 2 □ Cremetton 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE 4 ☐ Donation S ☐ Other (Specify) Woodlawn Cemetery 7/11 Woodlawn, Maryland 21. SIGNATURE OF TUNERAL SET Will Tiam C. Brown Community F/H 1206 W. North Avenue ark FART I. Enter the disease, or complications that caused the deeth. Do not enter tha mode of dying, such as cardiac or respiratory errest, Approximate shock, or haert fallure. List only one cause on each line. Interval Betwe IMMEDIATE CAUSE (Fine) Onset end Death heldestale diseese or condition___ resulting in death) DUE TO (OR AS A CONSEQUENCE OF Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a, WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO OF DEATH? 1 TES NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\square\) NO \(\mathbb{Q}\) UNCERTAIN \(\square\) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER:
4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 TES NO Inpetient 2 - ER/Outpetient 3 - DOA 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Naturel 8 Pending Investigation 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Rown, State) 8 Could not be 4 🗌 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the beels of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 196. SIGNATURE AND TITLE OF CERTIFIED 25s. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) witten



3. TIME OF DEATH

10d. INSIDE CITY

1 YES 2 NO

WHITE

interval Between

Onset and Death

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

Jul 95

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8. BIRTHPLACE (State or Foreign

MARYLAND

U.S.A.

14. RACE — American Indian, Black, White, etc.

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Specify:

REG. NO

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DAY

1995

1932

YEAR

COUNTY OF DEATH

2. DATE OF DEATH

7. DATE OF BIFTTH

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IF UNDER 24 HRS.

FOR STATE REGISTRAR

MELVIN

4. SOCIAL SECURITY NUMBER

OECEDENT'S NAME (First, Middle, Last)

HENRY

GRUBE

6. AGE (In vrs. last birthday)

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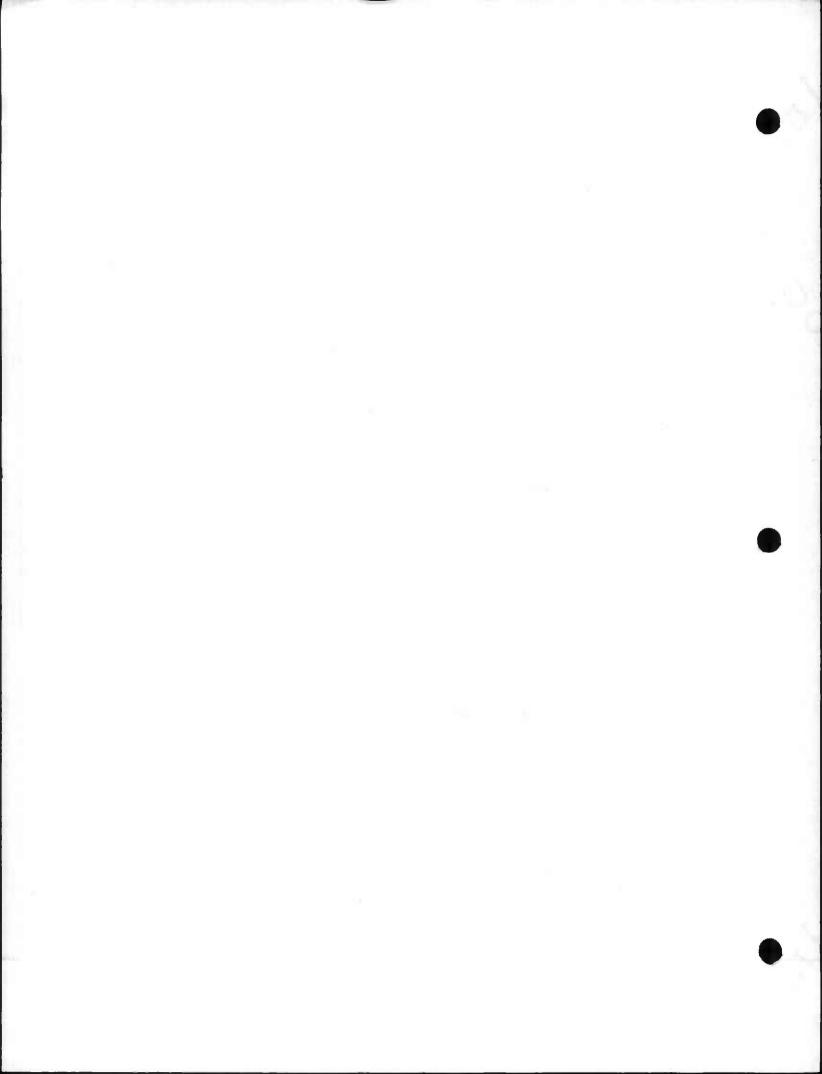
Feb 09 215-28-0972 1 M 2 F 63 permit. Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street and number, 96, CITY, TOWN OR LOCATION OF OFATH DIRECTOR 210 S. Crain Highway Apt. H Glen Burnie RESIDENCE OF DECEDENT 10c CITY TOWN OR LOCATION ANNE ARUNDEL GLEN BURNIE MARYLAND FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE burial-transit 21061 210 CRAIN HIGHWAY, SOUTH, APT. H retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-1 Never Married 2 Married If yes, specify Cuban, Maxican, Puarto Rican, etc.) 3 Widowed 4 Divorced 1 TYES 2 NO Specify BY use as the COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Spe (Give kind of work done life. Do NOT use retired.) detached for Elementary/Secondary (0-12) College (1-4 or 5+) FOOD STORES FORK LIFT OPERATOR UNKNOWN UNKNOWN once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at HARRISON GRUBE CARRIE BE Should 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, Stete, Zip Code 2 1510 INGALLS ROAD, GLEN BURNIE, MD. 21061 page 5 s RUTH A. BLAIR ě must be 20a METHOD OF DISPOSITION
1 ABurial 2 Cremation 3 Ramoval from State hours after death. Page 6 may 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State funeral director, GLEN HAVEN MEMORIAL PARK GLEN BURNIE, MD. 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF PUBLISHED MERVIND DICENSES 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 been signed by the attending physician and completely filled in by the it, of Health and Mental Hygiene prior to burial, cremation, or removal. medicai the diseases, or complicatione that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23. PAST I. Enter or heert fallure. List only one cause on each line. shock. IMMEDIATE CAUSE Final the diseese or cond AcuteCardio-Respiratory Failure event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF) executed traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate death certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury other 1 DUE TO (OR AS A CONSEQUENCE OF): that initiated evente resulting in death) LAST 10 PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 1 TYES 2 X NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO | Dept. 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) THE FUNERAL DIRECTOR: After this certificate filed within 72 hours after death with the State EXAMINER? HOSPITAL OTHER: ATTENDING PHYSICIAN: 1 X YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 ☐ Nursing Homa 5X Residence 8 ☐ Other (Specify) 10 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 X Natural 5 Pending BY 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 100 6 Could not be COMPLETED 4 Homicide 28 If Item OR / 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II ation and/or investigation, in my opinion, death occured at the time, data and placa, and dua to the cause(s) and menner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE DEPUTY D 06054 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William P. Jones M.D. 695 America Court Davidsonville, 31. DATE FILED (Month, Day, Year) 32 REGISTRAR'S SIGNATURE 2 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER 1 YEAR

DHMH-18 Rev 1/89

21035



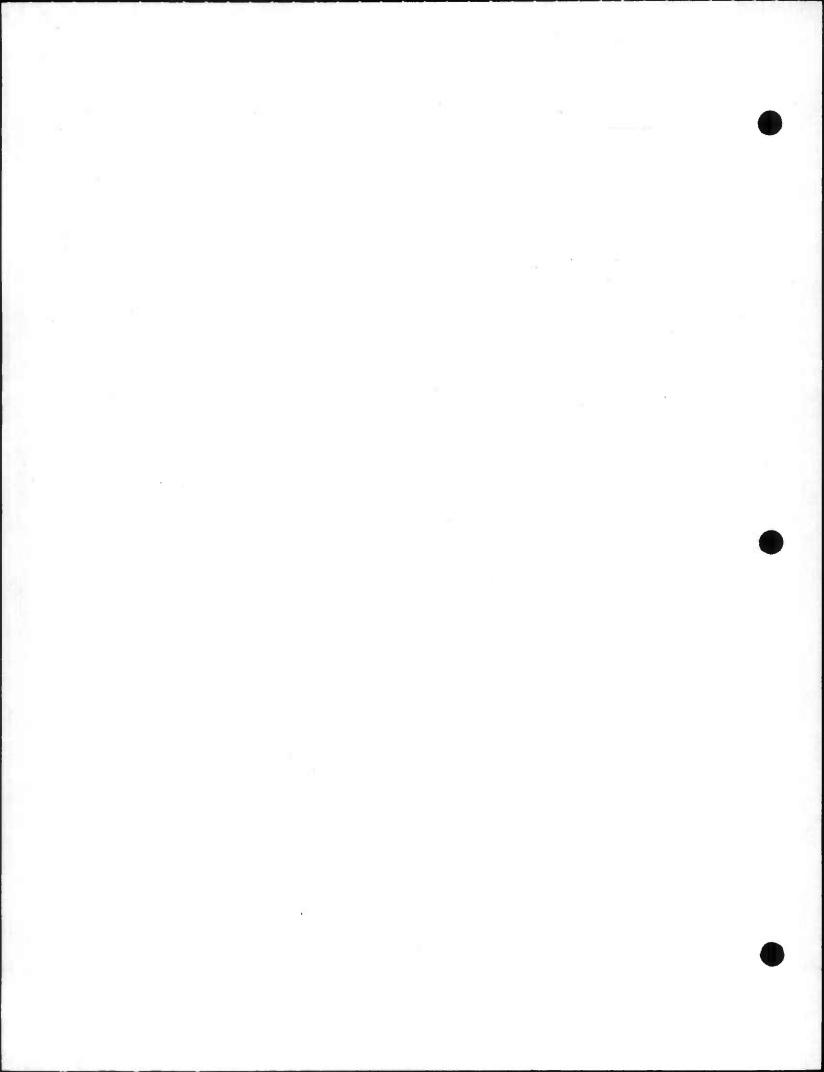
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BALTIMORE, MARYLANI	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	The	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	tem
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	1 - FOR STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTMENT		MENTAL HYGIEN				
	1. OECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DA		3. TIME OF OEATH		
	TINE 4. SOCIAL SECURITY NUMBER		ARVIN	JULY 08,	1995	18:33 P M			
	250-62-2823	1½2 M 2 □ F 65	6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE MONTHS DAYS HOURS MIN. 9/			Cou	RTHPLACE (State or Foreign Intry) Carolina		
œ	, and the same of	FACILITY NAME (If not institution, give street end number) 9b. Ci				9c. COUNTY OF	DEATH		
DIRECTOR	UNION MEMORIAL	E.R.	BAL'	TIMORE		n	ı/a		
REC	10a. STATE 10b. COUNTY		10c. CITY, TOWN OF	LOCATION			10d. INSIDE CITY LIMITS?		
	Maryland 100. STREET AND NUMBER	n/a	Balti				1 X YES 2 NO		
RA	1637 Chilton St	reet		10f. ZIP CODE 21218	0	100	F WHAT COUNTRY?		
S		12. WAS DECEDENT EVER IN U.S.	ARMED 13. W	AS DECENDENT OF HISPA			SA ACE — American Indien.		
BY FUNERAL	1 Never Married 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 Types 2 IF YES, GIVE WAR OR DATES 10/16/52-8/	NO If	yes, specify Cuben, Mexic YES 2 NO Speci	nn, Puarto Rican, etc.)	91	eck, White, atc.		
COMPLETED	15. DECEOENT'S EDUCA (Specify only highest grade or	TION 18e. propleted)	DECEDENT'S USUAL OCC (Give kind of work done du	CUPATION wing most of working	16b. KIND OF BUS	SINESS/INDUSTRY	,		
Ë		Coffege (1-4 or 5+)	ille. Do NOT use retired.) Farm Har	nd	F	arm			
OM	8th 17. FATHER'S NAME (First, Middle, Last)				AME (First, Middle, Meiden	Pumama)			
	George W. Harv	in			Williams	Surrieme)			
TO BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAJLING ADORESS (Street and Number or Rural		n, State, Zip Code)			
F	Mable Gamble		1637 Chi1	ton Stree	et, Balto	., MD.	21218		
	20a, METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remov	of from State cometery,	CE AND DATE OF OISPOSIT crematory or other place)	1/ 1.		CATION — City or			
	4 Donation Other (Specify)	Gar		est Vet.		ngs Mi	11s, MD.		
i.	*XOLORY	0 100	LE LE	ROY O. DY	TETT & SO	N FUNE	RAL HOME		
	23. PART I, Enter the disease, or co-	inplications that caused the	death. Do not enter ti	he mode of dying, suc	h as cardiac or respi	ratory arrest,	Approximate		
	ahock, or heart failure. List only one cause of each line. Interval Between Onset and Death								
	resulting in death) Arteriosclerotic Cardiovascular Disease								
_		DUE TO (OR AS A CON	SECUENCE OF):						
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate	DUE TO (OR AS A CON	SEOUENCE OF):						
ICA	cause. Enter UNDERLYING CAUSE (Disease or injury								
Ħ.	that initiated events resulting in death) LAST	DUE TO (OR AS A CON	SEOUENCE OF):						
S	d.								
AL.	PART II. Other significant conditions	contributing to deeth but no	t resulting in the und	eriying ceuse given in	Part i. 24a. WAS AN PERFOR		4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
MEDICAL					1 YES 2	№ мо	COMPLETION OF CAUSE OF DEATH?		
	DID TORACCO LISE CONTRI	PLITE TO CALIER OF D	ATIL VEC -	0 🖂			1 TYES 2 XNO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
₹	25. WAS CASE REFERRED TO MEDICAL	26. Pt	ACE OF DEATH (Check on	ly one)					
SICIA	EXAMINER?	26. Pt	OTHER:		8 Other (Specify)				
PHYSICIA	EXAMINER? TXYES 2 NO 27. MANNER OF DEATH	HOSPITAL: Inpatient 2 X ER/Outpatient 28e. DATE OF INJURY	3 DOA OTHER: 4 Nursin	ig Home 5 Residence	8 Other (Specify) 28d, OE\$CRIBE HOW II	JURY OCCURED			
BY PHYSICIAN:	EXAMINER?	OSPITAL: Inpetient 2 X ER/Outpetient 28e. DATE OF INJURY (Month, Day, Year)	3 DOA OTHER: 3 DOA 4 Nursir 28b. TIME OF INJURY	Bc. INJURY AT WORK? 1 YES 2 NO		NJURY OCCURED			
B	EXAMINER? X X X X X X X X X	HOSPITAL: Inpatient 2 X ER/Outpatient 28e. DATE OF INJURY	3 DOA OTHER: 3 DOA 4 Nursir 28b. TIME OF INJURY	Bc. INJURY AT WORK? 1 YES 2 NO			il Route Number,		
B	EXAMMER? XXYES 2 NO 27. MANNER OF DEATH 1 X Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only) 1 CERTIFYING PHYSICIA	10SPITAL: npetient 2 X ER/Outpetient 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY — At	3 DOA OTHER: 4 Nursir 28b. TIME OF INJURY M home, ferm, street, factor death occurred at the tim	Bc. INJURY AT WORK? 1 YES 2 NO y, office	28t. LOCATION (Street a City or Town, State)	nd Number or Rura			
	EXAMMER? XXYES 2 NO 27. MANNER OF DEATH 1 X Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only) 1 CERTIFYING PHYSICIA	AN: To the best of examination and/ 10SPITAL: Place OF INJURY	3 DOA OTHER: 4 Nursir 28b. TIME OF INJURY M home, ferm, street, factor death occurred at the tim	Bc. INJURY AT WORK? 1 YES 2 NO y, office	28t. LOCATION (Street a City or Town, State) to the ceuse(a) and men time, date and place, en	nd Number or Rurs			
BE COMPLETED BY	EXAMINER? X X X X X X X X X	28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY — At building, etc. (Specify) AN: To the best of my knowledge,	3 DOA OTHER: 4 Nursir 28b. TIME OF INJURY M home, ferm, street, factor death occurred at the tim	Bc. INJURY AT WORK? 1 YES 2 NO y, office e, date and place, end due nion, death occured at the	28t. LOCATION (Street a City or Town, State) to the ceuse(a) and men time, date and place, en	nd Number or Rurs ner ea stated, d due to the cause 29d. DATE SIGNI	e(e) and menner ee stated. ED (Month, Day, Year)		
E COMPLETED BY	EXAMINER? X X X X X X X X X	AN: To the best of my knowledge, On the bests of examination and/	3 DOA OTHER: 4 Nursir 28b. TIME OF INJURY M home, ferm, street, factor death occurred at the tim or investigation, in my opi	Be. INJURY AT WORK? 1 YES 2 NO y, office e, date and place, and due nion, death occurred at the 29c. LICENSE NUI OCME	28d, OESCRIBE HOW II 28t. LOCATION (Street a City or Town, State) to the ceuse(a) and men time, date and place, en-	nd Number or Rural mer ea stated. d due to the cause 29d. DATE SIGNI	e(e) and menner ee stated. ED (Month, Day, Year) 09,1995		
BE COMPLETED BY	EXAMINER? XXYES 2 NO 27. MANNER OF DEATH 1 X Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 X MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO one) Donald G. Wright	AN: To the best of my knowledge, On the bests of examination and	3 DOA OTHER: 4 Nursir 28b. TIME OF INJURY M home, ferm, street, factor death occurred at the tim or investigation, in my opi	Be. INJURY AT WORK? 1 YES 2 NO y, office e, date and place, and due nion, death occurred at the 29c. LICENSE NUI OCME	28d, OESCRIBE HOW II 28t. LOCATION (Street a City or Town, State) to the ceuse(a) and men time, date and place, en-	nd Number or Rural mer ea stated. d due to the cause 29d. DATE SIGNI	e(e) and menner ee stated. ED (Month, Day, Year) 09,1995		
BE COMPLETED BY	EXAMINER? X X YES 2	AN: To the best of my knowledge, On the bests of examination and/	3 DOA OTHER: 4 Nursir 28b. TIME OF INJURY M home, ferm, street, factor death occurred at the tim or investigation, in my opi	Be. INJURY AT WORK? 1 YES 2 NO y, office e, date and place, and due nion, death occurred at the 29c. LICENSE NUI OCME	28d, OESCRIBE HOW II 28t. LOCATION (Street a City or Town, State) to the ceuse(a) and men time, date and place, en-	nd Number or Rural mer ea stated. d due to the cause 29d. DATE SIGNI	e(e) and menner ee stated. ED (Month, Day, Year) 09,1995		

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	FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		ENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last) James Hood	JAMES EDWAR	RD HOOD,	SR		July 2, 1	995 YEAR	3. TIME OF DEATH 6:30 A.
	4. SOCIAL SECURITY NUMBER 220-12-6943	1 🔀 M 2 🗆 F	In yrs. lest birthday) 8 YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Morith, Day, Year) 06-10-192.	8. Bif	THPLACE (State or Foreign untry) RYLAND
CTOR	9a. FACILITY NAME (If not institution, give VA Medical Center RESIDENCE OF DECEDENT			BALTIM	ORE	TH	9c. COUNTY OF	
DIRE	MARYLAND 10b. COUNT	ANNE ARUNDEI		y, town on locat	LEN BURNI	E	-	10d. INSIDE CITY LIMITS? 1 YES 2XX NO
VERAL	100. STREET AND NUMBER 18 PHYLLIS DRIVE			101	21060			S.A.
BY FUNI	1 Never Married 2 Married 3 Widowed 4 Divorced	12: WAS DECEDENT EVER IN FORCES? VIX YES IF YES, GIVE WAR OR DA	U.S. ARMED ·2 NO NTES	If yes, sp	ecity Cuban, Maxican, 2 NO Specify:	ORIGIN? (Specify Yea Puerto Ricen, etc.)	B	ACE — American Indian, ack, White, etc.
PLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	Cation occupieted) Callege (1-4 or 5+) N/A	(Give kind of a life. Do NOT us	USUAL OCCUPATION Work done during move retired.) IVER	DN st of working	16b. KIND OF BUS		1
at once.	17. FATHER'S NAME (First, Middle, Last) VERNON JAMES	HOOD			18. MOTHER'S NAMI	(First, Middle, Maiden		NI
TO BE	19a. INFORMANT'S NAME (Type/Print) VIRGINIA ELIZABET	H HOOD			and Number or Rural Ro	Ite Number, City or Town	n, State, Zip Code)	
or must be	20a. METHOD OF DISPOSITION X Burlel 2 Cremation 3 Ren 4 Donation 5 Other (Specify)	corn State Com	PLACE AND DATE of the effect, cremetory or or EN HAVEN	MEMORIA	L PARK	7/7/95 GL	CATION — CHY OF EN BURN	IE, MD.
examiner	21. SIGNATURE OF FUNERAL SERVICE LI	l C.Sa	Stran	1 SEC	OND AVENU	SINGLETOE, S.W.,G	ON FUNE LEN BURI	RAL HOME, NIE,MD.210
event, the medical	23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	Aspiration	MICH 11000	ia	da of dylng, auch	as cardiac or reaple	ratory arrest,	Approximata Interval Betw Onset and D
or other traumatic	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	с	CONSEQUENCE OF					
shows any Injury, o	PART II. Other significant condition	ns contributing to death be	ut not resulting	n the underlying	g cause given in Pr	PERFOR	MED?	4b. WERE AUTOPSY FINDS AWAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH?
1, or item 23 shows an HYSICIAN: MEDIC	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		F DEATH YE	'H (Check only one)	UNCERTAIN	M		1 - YES 2 NO
ted, or ite PHYSI	1 TYES 2 NO NO 27. MANNER OF DEATH	HOSPITAL: 1 54 Inpetient 2 ER/Outpet 28a. DATE OF INJURY (Month, Day, Year)	28b, TIM	E OF 28c. INJ	e 5 Residence 6 URY AT 2 PK?	Other (Specify)	NJURY OCCURED	
	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide detarmined	28a. PLACE OF INJURY building, atc. (Speci	— At home, farm, s		res 2 No	St. LOCATION (Street a City or Town, State)	and Number or Run	al Route Number,
ANT: If item 2 COMPLET		ICIAN: To the best of my knowle						e(a) and manner as state
IMPORTANT: If item 28 is ma TO BE COMPLETED BY	29b, SIGNATURE AND TITLE OF CERTIFIE	" C = MD			29c. LICENSE NUMB	ER		ED (Month, Day, Year)
	30. NAME AND ADDRESS OF PERSON WA Kenneth Lin, M.E	., Univ. of 1	1D, 22 S		ene St.,	Baltimore	, MD 2	1201
1	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	TURE					



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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH July 3. TIME OF DEATH PM 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 8. AGE (In vrs. lest birthdev) 7. DATE OF BIRTH (Month, Day, Year 8. BIRTNPLACE (State or Foreign Country) 13-20-0185 DAYS HOURS MIN. 1 M 2 X F YRS. completely fined in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Secours Baltimore DIRECTOR NA Dital RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY NH 1 YES 2 NO Baltimore FUNERAL 10a STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 505 54 lask 21216 U. the hospital or attending physician. 1/1. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS RACE — American Indian, Black, White, atc. 1 Never Married 2 Married BY Specify: 3 Widowed 4 Divorced Black COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY during most of working (Give kind of work done life. Do NOT use retired.) ndary (0-12) College (1-4 or 5 +) Co. ocket Marken othing 10th grade NA 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle T Page 6 may be retained by a BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (S 2 P 34 3 40 9 20a, METHOD OF DISPOSITION

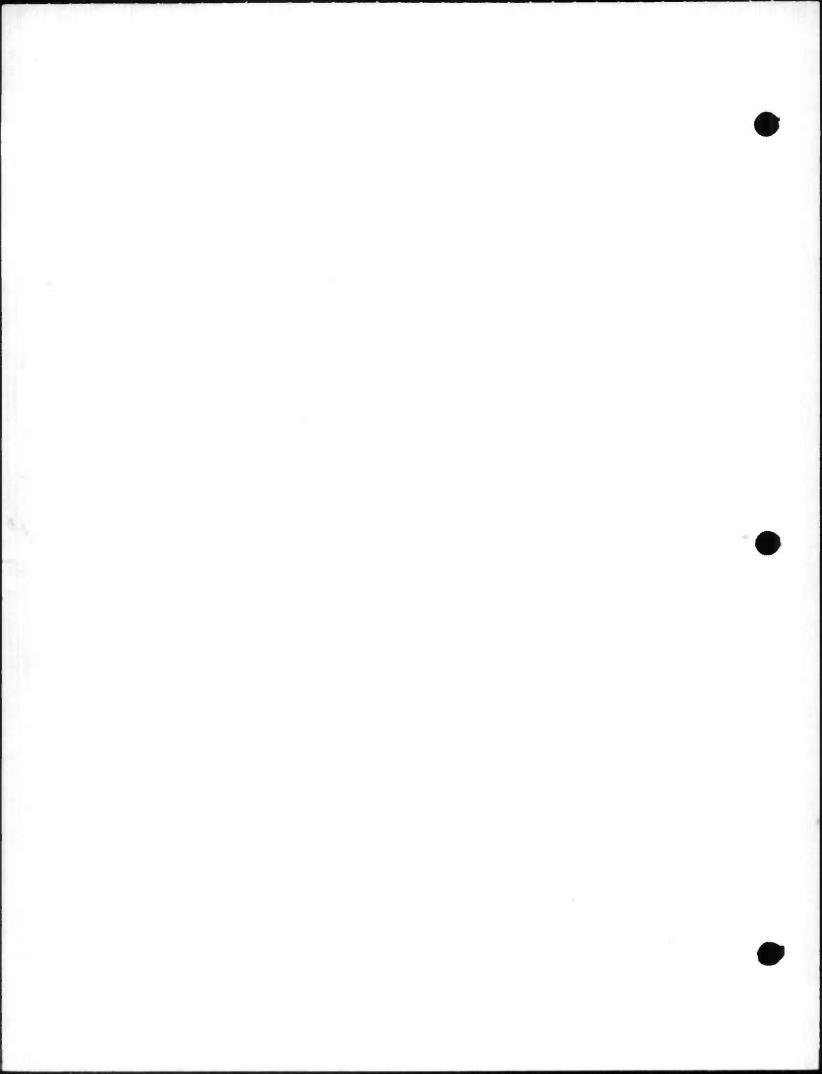
1 DEBurial 2 Cremation 3 Removal from State 206. PLACE AND DATE OF DISPOSITION (Name of DATE 20s: DOCATION - City or Town, State must 7/6/95 22. NAME AND ADDRESS OF FACILITY
March F. L. F. Donation 5 Other (Specify) allstown, Ma 21. SIGNATURA OF PUNERAL SERVICE LICENSEE examiner layh F. H. West 21215 23. PART I. Inter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart siliure. List only one cause on each line. to Mod medical Approximata Interval Batwe 6 IMMEDIATE CAUSE (Final **Onset and Death** cremation, the disease or condition resulting in death) traumatic event, DUE TO JOH AS A CONSEQUENCE OF) and com o burial, tati CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): been signed by the attending physician a t. of Health and Mental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 Injury. PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24s. WAS AN AUTOPSY MEDICAL PERFORMED? any 1 YES 2 NO shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO INCERTAIN I PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Hem this certificate h HOSPITAL: OTHER: 1 TYES 2 NO | Nonpatient 2 | ER/Outpetient 3 | DOA 4 Nursing Home 5 Residence 8 Other (Specify) 0 27. MANNEB OF DEATH 28s. DATE OF INJURY (Month, Day, Year) TIME OF 28c, INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED marked. 1 Natural 5 Pending 1 YES 2 NO . DIRECTOR: After the hours after death v BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 8 Could not be 4 Homicide 28 Hem 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL O TO THE FUNERAL DI be filed within 72 ho IMPORTANT: If ite 2 MEDICAL EXAMINER On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF DERTAPE 29c, LICENSE NUMBER 29d. DATE SIGNED (Month. BE Day, Year 2

31. DATE FILED (Month, Day,

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

DONCHIE

32. REGISTRAR'S SIGNATURE Skudger Rando



DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	Pages 1,		
or attending physician.	ir use as the burial-transit-permit. F		
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scuted within 24 hours after death. Page 6 may be in	nd completely filled in by the funeral director, page 5	burial, cremation, or removal.	atic event the madical examiner must be un
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed writing 24 hours after death. Page 6 may be many or attending physician.	tificate has been signed by the attending physician an	h the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal,	APPRIANT Hillen 28 is marked or liem 23 shows any injury or other trainmain event the medical avaminar must be any
TO THE HOSPITAL OR ATTENDING PHYSICI	TO THE FUNERAL DIRECTOR: After this cert	be filed within 72 hours after death with the	IMPORTANT: H Ham 28 to marked o

BALTIMORE, MARYLAND 21215-0020

Item1,g-725,7-12-95,perf.h.,dk

FOR
STATE
STATE OF MAR

1 - BEGISTEAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	-	REGISTRAR		CERTIF	CATE OF	DEATH	REG. NO			
	1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH	
- 1		madale James	Hamil)	ton			MONTH D	AY YEA	LI'IN Pu	
	-1	4. SOCIAL SECURITY NUMBER 5.		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	199)	7701	
	- 1	2/2			MONTHS DAYS	HOURS MIN.	(Month, Day, Year)	a. B	IRTHPLACE (State or Foreign ountry)	
		26-0308		YRS.			JAN. 18	1925	S.C.	
	- 1	9e. FACILITY NAME (If not institution, give street	and number)		9b. CITY, TOWN	OR LOCATION OF	DEATH	9c. COUNTY C	OF DEATH	
- E		Grand SAM	face		BA	110.		11	/,	
1 5		RESIDENCE OF DECEDENT	105%		121	1/0.		1 /4/	A.	
DIRECTOR		10e. STATE 10b. COUNTY	,	10c. CITY	, TOWN OR LOCA	TION			10d, INSIDE CITY	
5		md.	N/A		BALT	-1			LIMITS?	
		10e. STREET AND NUMBER	7///						1 YES 2 NO	
FUNERAL			, , ,		10	f. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?	
	. N	1504 Prentria	ge Rd			2/2	39	21	·5.A.	
5		11. MARITAL STATUS 12	. WAS DECEDENT EVER	N U.S. ARMED	13. WAS DEC	CENDENT OF HISPA	ANIC ORIGIN? (Specify Yes	or No — 14. F	ACE - American Indian.	
	- 19	1 Never Married 2 Married	FORCES? 1 YES	NO	II yes, sp	ecify Cuben, Mexic	en, Puerto Rican, etc.)		Black, White, etc.	
₽		3 Widowed 4 Divorced	in real, dive than on a	AI ES	1 1 163	NO Spec	my:		Specify &	
ي ا	: 1	15. DECEDENT'S EDUCATION	ON	16a. DECEDENT'S	USUAL OCCUPATI	ON	401 81110 05 011	1 6	1150	
		(Specify only highest grade com	pleted)	(Give kind of w	ndk done during me	ost of working	16b. KIND OF BUS	SINESS/INDUSTR	(4	
15		Elementary/Secondary (0-12)	ollege (1-4 or 5+)				00-		11	
×ε		124	NIA	HOUS	ewif-	e	KKIVI	91E,	MOME	
COMPLETED		17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S N	AME (First, Middle, Maiden	Sumame)		
- 11	- 11	STONEWALL.	JACKSO!	-3		1.1	a Cha	mber		
A H	4	19e. INFORMANT'S NAME (Type/Print)	VI.CA.30.		ADDRESS (Comet		Route Number, City or Tow			
<u> 1</u> 2	9	D- 1. 1/-	· / -	49	0					
-		DRENDA TTAN	1,1/10n	282	6 Fre	551 m	Anst. B	17.140.	md21216	
		20e. METHOD OF DISPOSITION 1 De Buriel 2 Cremetion 3 Removal	200	. PLACE AND DATE O	FDISPOSITION (N	ame of	DATE 20c. LO	CATION — City of	or Town, State	
E E	1	4 Donation 5 Other (Specify)	Irom state cer	meter Brematory or ot	her place)		1001/2 13	1/10	md	
196	- 11	21. SIGNATURE OF FUNERAL SERVICE LICENS		27.77		ND ADDRESS OF F	ACILITY		1114	
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EXS	1	Xalsten	SIE		1	13001	CAROLIN	11/	SAIM med	
8		23. PART I. Enter the disesses, or com	olications that cause	d the deeth. Do n	of enter the mo	de of duing au	ch se certise or man	277 -		
B B B B B B B B B B B B B B B B B B B	1	shock, or heart fellure. List	only one cause on e	esch line.	or ones the me	oe or uying, su	cir as cardiac or respi	ratory arrest,	Approximate Interval Between	
9	Ш	IMMEDIATE CAUSE (Final Onset and Death								
-	- 11	diseese or condition resulting in death)	HCUITE	EMI	10CAR	LAIGS	INFAR	CTIA	N / Houn	
E			DUE TO (OR AS	A CONSEQUENCE OF):		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, , , ,		
ATION			Cana	1 men	mor		7,0-10	-	İ	
CERTIFICATION		Sequentially list conditions, b	DUE TO (OR AS	A CONSEQUENCE OF	17 1212	ing	DISEASO		<u> </u>	
E A		if any, lesding to immediate cause. Enter UNDERLYING	7 10			,				
		CAUSE (Disesse or Injury	DIASE			LITU	5			
TIFIC		that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF):					
5 E		d								
		PART II. Other significant conditions co	ontributing to deeth I	out not resulting i	n the underlyin	g cause given in	Perti. 24s. WAS AN		24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
		END-STAGE	KEN	AL 7	115FA	Car	1 YES 2		COMPLETION OF CAUSE	
				'				IN NO	OF DEATH?	
shows : MEI		DID TODA COO HEE CONTINUE				-		1	1 TES 2 NO	
PHYSICIAN:		DID TOBACCO USE CONTRIB	UIE TO CAUSE C				IN 🔲			
		25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEAT						
			OSPITAL: Inpatient 2 VER/Out	patient 3 DOA	OTHER:	se 5 Residence	8 Other (Specify)			
BY PHYSICIA		27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME		IURY AT	28d. DESCRIBE HOW I	N ILIEV OCCUPE		
D 0		1 Netural 5 Pending	(Month, Day, Year)	INJ	JRY WO	ORK?	200. DEGOINDE HOW	NOON! OCCONE	<i>'</i>	
B a		2 Accident Investigation			M 1					
		3 Suicide s Could not be	28e. PLACE OF INJURY building, etc. (Spe	f — At home, ferm, s cify)	treet, fectory, offic	•	28f. LOCATION (Street (City or Town, Stete)		ral Route Number,	
		4 Homicide determined					only or lown, dieley			
COMPLETED		290. CERTIFIER	to We also A least to the							
- d		(Check only								
D BE COMPLE		2 MEDICAL EXAMINER: O	n the beale of examination	n end/or investigation	ı, in my opinion, d	leath occured at th	e time, date end place, en	d due to the ceu	se(e) end menner ee stated.	
§ O	- 18	394- SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU	IMBER	204 DATE BIO	NED (Month, Day, Year)	
품	1	6/11.1 -	445	15000		7710	25	A SOL DATE SIGN	(MUTITI, Day, TOBIT)	
<u>₹</u> 2	1	- william	10	CIHRO	106157	U568	20	1/	11/95	
-	It	SO NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,				1		
6	1	VONATHAN D	14161150	N, MO	740	02 400	K RD	212	04	
1	1	31. DATE FILED (Month, Day Year)	32. BEGISTRANS SIGN	ATURE	1	1010	1			
1		IIII 7 0 MUL	Stille dilleve	son Roulall			•			
		. 101 T % 1999 I	100000000000000000000000000000000000000	den i mi Evitori						

Allerson in the son in.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

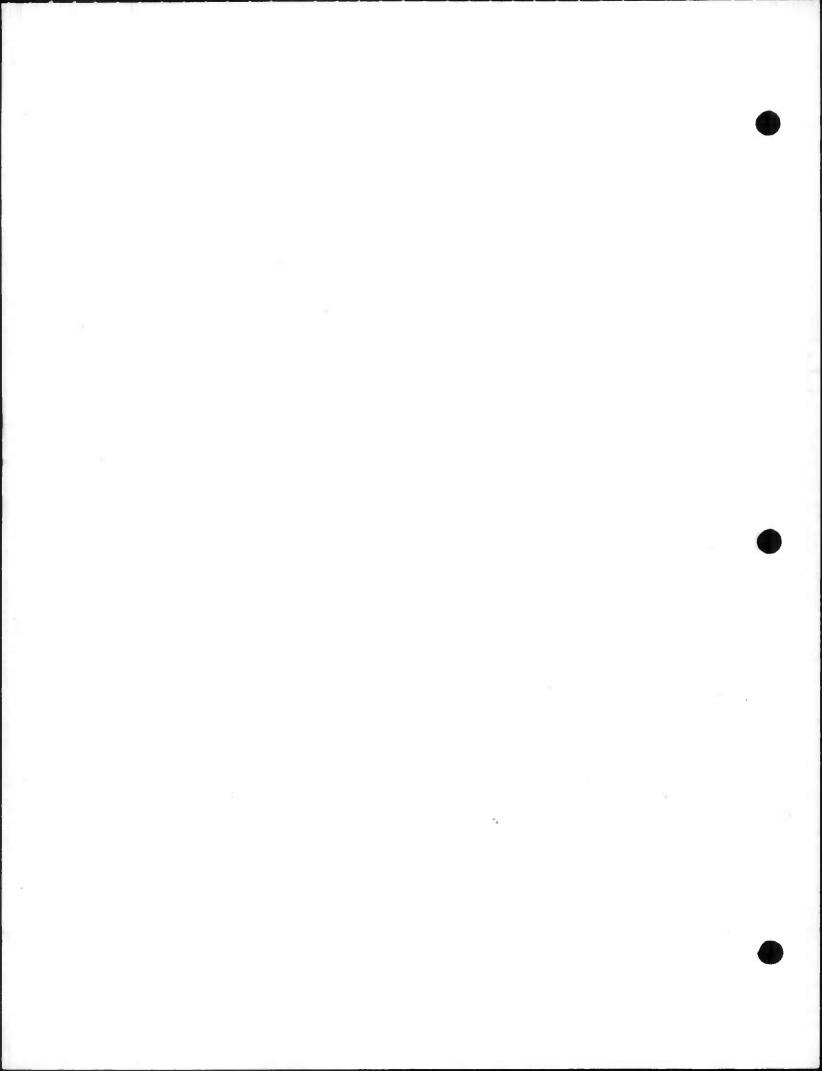
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR			<u> </u>	CATE	F DEA	IH	R	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last Mamie Delor:	•	TOTTADD					2. DATE OF I	DAY		YEAR	3. TIME OF DEATH
	Mamie Delor:		IOWARD					July '		95		9:30 A M
	The second secon	5. SEX	6. AGE (In yrs. les		IF UNDER 1 YEA		R 24 HRS.	7. DATE OF E (Month, De	SIRTH y, Year)		8. BIRTH Countr	IPLACE (State or Foreign y)
	212-32-8482	1 D M 2 😾 F	61	YRS.	Sept 3, 19			, 193	Maryland		ryland	
~		9e. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COU	NTY OF D	EATH
DIRECTOR	Franklin Square I	Franklin Square Hospital				n/a				Baltimore		
L C	10a. STATE 10b. COUN	toc. CITY	, TOWN OR LO	CATION						10d. INSIDE CITY		
1 %	Maryland n/a										l	LIMITS?
	10e. STREET AND NUMBER	LB	Baltimore 100, ZIP CODE					10a CITI	IZEN OF V	1 ▼ YES 2 □ NO		
FUNERAL	4929 Herring Run		21214					log. Offi		ISA		
Z	11. MARITAL STATUS	12. WAS DECEDENT	T EVER IN U.S. AR	MED	13. WAS I			IIC ORIGIN? (S	nacify Yes	or No		
	1 Never Married 2 Married FORCES? 1 YES 2 NIF YES, QIVE WAR OR DATES				if yes,	specify Cub	an, Maxica	n, Puarto Ricar	n, atc.)			- American Indian, White, etc.
BY	3 Widowed 4 Divorced		ALL DATES		1	ES 2 X NO	apecin	y:			Speci	Black
COMPLETED	15. DECEDENT'S ED (Specify only highest grad	DUCATION de cognisted)	100	has below to all and	JSUAL OCCUPA			16b. KIN	D OF BUSI	NESS/INC	DUSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+	Cuis	Do NOT use	r Serv	ice R	ng =:n/					
₩ M	High School.		Te	1.epho	ne Ope	rator		Ci	tiCo	rp		
18	17. FATHER'S NAME (First, Middle, Last)					18, MOT	HER'S NA	ME (First, Middle	e, Maiden S	lumame)		
BE	Eddie Berry					1	Rosa	Ford				
0	19a. INFORMANT'S NAME (Type/Print)		198	. MAILING	ADDRESS (Street	t and Numbe	or Or Rural I	Route Number, C	ity or Town,	State, Zip	Code)	
-	McKinley C. Howa	ard		4929	Herrin	a Run	Driv	ve Ba				
	20a. METHOD OF DISPOSITION 1 X Burial 2 Cremetion 3 Re-	move from State	20b. PLACE A	ND DATE O	F DISPOSITION	Nama of		Jûfy	20c. LOC	ATION —	City or To	wn, State
	Dulanev Valley Mem. Garden 13 Timonium, Maryland								aryland			
	21. SIGNATURE OF FUNERAL SERVICE L	LICENBEE	4		22. NAME	AND ADDRE	SS OF FA	CILITY Nut	ter	Fune	ral.	Homes, Inc
- 8	Lewest	EM	the		Ba1	Limor	nns i	Marylar	arkw	ay 2121		
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest,											
	anock, or neart failure. List only one cause on each line.									Interval Between Onset and Death		
	disease or condition											
1	metastatic Breast Cancer lyear Due To (or As A consequence of):									lyear		
z												
유	Sequentially list conditions, if sny, leading to immediats DUE TO (OR AS A CONSEQUENCE OF):											
2	cause. Entar UNDERLYING CAUSE (Disease or injury	G										
불	that initiated events resulting in death) LAST	OUE TO (OR AS A CONSEC	NUENCE OF	:						- 7	
CERTIFICATION	d											
	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS											
EDICAL								1	PERFORM			AWAILABLE PRIOR TO COMPLETION OF CAUSE
								_ 1	YES 2X	NO		OF DEATH?
2	DID TOBACCO USE CON	TRIBLITE TO CAL	ISE OF DEA	TH VE		ZI LINK	EDTAIN					1 TYES 2 NO
NA I	25. WAS CASE REFERRED TO MEDICAL	TRIBOTE TO CA			(Check only or		SEKIAH	1 1				
Sic	EXAMINER? 1 ☐ YES 2 ☑ NO	HOSPITAL:	FR/Outpetlant 3		OTHER:				7.11			
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF	INJURY	28b. TIME		NJURY AT	esidence	5 Other (Spi		IURY OCC	CLIBED	
	1 Natural 5 Pending	(Month, De	y, Year)	INJU	IRY	YES 2	¬ no				JONED	
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF	INJURY — At hor	ne, ferm, st				28f. LOCATION	N (Street an	d Number	or Rural R	oute Number
E	4 Homicide determined	building, e	etc. (Specify)					City or Tox	vn, State)			
COMPLET	29a. CERTIFIER 1 CERTIFYING PHY	SICIAN: To the best of r	my knowledge des	ath annual	l at the time of		200010			So un		
₩.	(Check only one) 2 MEDICAL EXAMIN	VER: On the basis of as	amination and/or is	m occurred	In my opinion	death occu	n, and dua	to the cause(a)	and mann	or se state	ed.	
- 1	296. SIGNATURE AND TITLE OF CERTIFIC					1						
BE	AND SIGNALONE AND THE OF CENTER	MIM					ense nuw 8487	IBER				(Month, Day, Ybar)
임	30. NAME AND AODRESS OF PERSON W	HO COMPLETED CAUS	E OF DEATH (ITEM	27) (Time 1	Print)	1 - 1				Ju	тту 9	,1995
	Dr. Myo Thant 900					nore.	Mary	land 2	21237			
	31. DATE FILED (Month, Day, Year)		R'S SIGNATURE							-		
		J. 1. M. J.	r Randall									
	JUL1 2 1995	THE WILLIAM	T PARTIE LA									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ex hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE	0F	MARYLAND /	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGII	ENE
		CI	ERTIFICATE	0	F DEAT	TH.		BEG I	NO

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTM	MENT OF HEALTH AND	MENTAL HYGIENE REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Last)	HOWARD		2. DATE OF DEATH	year 3. TIME OF DEATH					
1	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. last birthday)	UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRTHPLACE (State or Foreign					
	99. FACILITY NAME (If not irreditation, give atm	TIME OF YAS.	NTHE DAYS HOURS MIN.	June 9,1909	South Carolina					
TOR	2922 Park	Wood Ave,	Baltimo	DEATH 9c. COU	NTY OF DEATH					
DIRECTOR	Mary and 106. COUNTY	N/A 10c. SITY, T	OWN OR LOCATION		10d. INSIDE CITY LIMITS? 1 1 YES 2 NO					
FUNERAL	104. STREET AND NUMBER PARK	WOOD AVO	101. ZIP CODE	77 10g. CIT	IZEN OF WHAT COUNTRY?					
FUNE	11. MARITAL STATUS 1 Prover Merried 2 Merried	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 PRO	13. WAS DECENDENT OF HISPA It yes, specify Cuban, Mexic	NIC ORIGIN? (Specity Yes or No-	14. RACE — American Indian, Black, White, etc.					
B≼	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	1 YES 2 NO Speci		specify: Black					
COMPLETED	15. OECEOENT'S EDUC/ (Specify only highest grade of	completed) (Give kind of work	done during most of working	16b. KIND OF BUSINESS/INC	DUSTRY					
MPLE	Elementary/Secondery (0-12)	College (1-4 or 5+) Hom	emaker	Own 1	Home.					
	17. FATHER'S NAME (First, Middle, Leet)									
TO BE	194, INFORMANT'S NAME (Type/Print)	19b. MAILING AD	ORESS (Street and Number or Rural	Route Number, City or Town, State, Zir.	o Code)					
F	JETALAIN E	Miller 12920	L Par KWIOG	od Ave.Bai	to, Md, 2/2/7					
	1 V Buriet 2 Cremation 3 Removed Donation 5 Other (Specify)	20b. PLACE AND DATE OF COMMENT OF THE COMMENT OF TH	ISPOSITION (Name of	DATE 200. LOCATION -	Olline Md.					
	21. SIGNATURE OF FUNERAL SERVICE/LICE	MREE D D	22. NAME AND ADDRESS OF F	CUCS Funer	al Home					
\vdash	23. PART I/ Enter the difference or co	proplications that caused the death. Do not	1222 W. N	orth Ave, Ba	17. Md. 21216					
	shock, or heart fallure. Li IMMEDIATE CAUSE (Final	ist only one cause on each line.		on as carolac or respiratory an	Approximate Interval Between Onset and Death					
	disease or condition resulting in death)		ulus.		3 4/20					
z	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury Due to (or as a consequence of): Discharge graph, Many Year, Due to (or as a consequence of): and typertensian.									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING									
IFI	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONSEQUENCE OF):		10100000						
CER	resulting in death) LAST									
A.	PART II. Other significant conditions	contributing to death but not resulting in t	ha undsriying cause givan in	Part I. 24s. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO					
AED!	COPD	7 00 0000		1 🗆 YES 2 🗹 NO	COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO					
N.		IBUTE TO CAUSE OF DEATH YES		N 🗆	1 12 2 1 10					
PHYSICIAN: MEDIC			Check only one) THER: Numing Home 5 E Residence	6 Other (Specify) Lican	red Home.					
PHY	27. MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year) 28b. TIME O	F 28c. INJURY AT	28d. DESCRIBE HOW INJURY OC	0.01					
ВУ	2 Accident Investigation	28e. PLACE OF INJURY — At home, term, street	M 1 YES 2 NO	281. LOCATION (Street and Number	or Rural Route Number					
E	3 Suicide a Could not be determined City or Town, Street factory, office building, stc. (Specify) 289. PLACE OF INJURY — At home, term, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, Stete)									
COMPLETED		IAN: To the best of my knowledge, death occurred a On the bests of examination end/or investigation, is								
BE	296. SIGNATURE AND THILE OF CENTIFIER	- 1 M D	29c. LICENSE NU D - 3 {	MBER 29d. DATI	E SIGNED (Month, Day, Year)					
10	MALIKA WAS	COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print R. M.) . , (00 f	J. BROADW	AY, BALTIMO	ORE. MD-21231					
	JUL 1 2 1995 Julia	132. REGISTRADE SIGNATURE								

af-transit permit. Pages 1, 2, 3 should

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

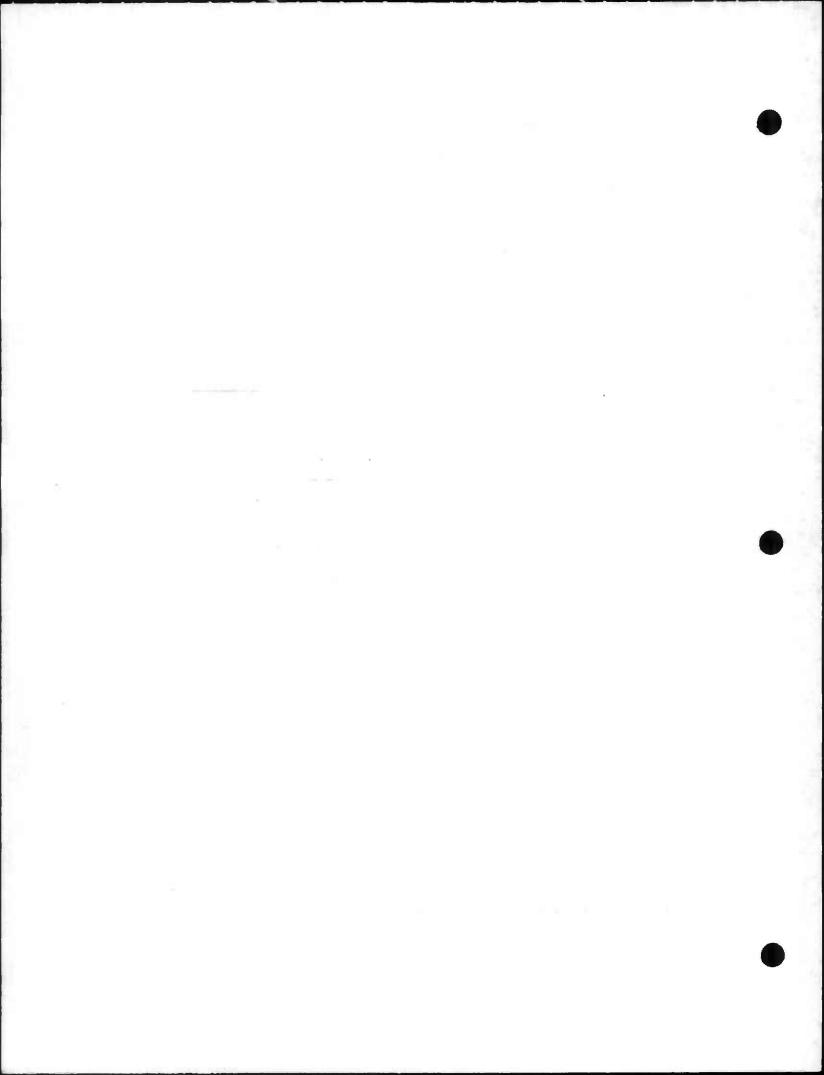
	REGISTRAR		-		WIF O	F DEATH	r	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF	DEATN		3. TIME OF DEATN		
	George Ho	OK Ge	George Edward Hook				MONTH	07	95	3:00A M		
			AGE (In yrs. last i				-					
. 1		S. SEA B.	PIGE (III yrs. lest I	240	UNDER 1 YEAR		7. DATE OF I (Month, De	BIRTN ly, Your)	Coun	HPLACE (State or Foreign try)		
	213-07-7279	86	YRS.		1		8/09	Mar	yland			
	9e. FACILITY NAME (If not institution, give str	98	. CITY, TOW	OR LOCATION OF D			COUNTY OF					
Œ	Johns Hopkins 6		0									
DIRECTOR	RESIDENCE OF DECEDENT											
낊	AAA CYAYE											
<u>E</u>	Marialand	Baltimo	40	1001 0111, 1	OWN ON LOC		t Howar	d		10d. INSIDE CITY LIMITS?		
0	Maryland	Buttillo	ne			1000	Howar	·u		1 TYES 2 X NO		
A	10e. STREET AND NUMBER			10f. ZIP CODE 10g. CITIZ			. CITIZEN OF	WHAT COUNTRY?				
FUNERAL	0201 Todd Augus		0.1			1052 United			04-4-4			
Ξ	9304 Todd Avenu	VER IN U.S. ARM							States			
II.	1 Never Married 2 Merried	FORCES? 1			13. WAS D	ECENDENT OF HISPA specify Cuban, Mexic	NIC ORIGIN? (S an, Puerto Rica:	pecify Yes or N n, etc.)	o- 14, RAC Blac	E — American Indian, k, White, etc.		
ВУ	3 € Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES			ES 2 NO Speci		, ,	Spec	offy:		
	~									white		
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)	16a. DECI	EDENT'S USI	JAL OCCUPAT	TION most of working	16b. KIN	ID OF BUSINES	S/INDUSTRY			
血	Elementary/Secondary (0-12)	College (1-4 or 5+)	Itte. C	Oo NOT use re	tired.)	nost or working						
- E	11 Years		T.	Foreman				eel Inc	luctur			
8	17. FATNER'S NAME (First, Middle, Last)			18. MOTHER'S NAME (F								
Ö						347000000000000000000000000000000000000	1	o, manager desire				
BE	George W. Hook						Crabt					
2	19a. INFORMANT'S NAME (Type/Print)		19b.	MAILING AD	DRESS (Stree	t and Number or Rural	Route Number, C	City or Town, Sta	te, Zip Code)			
F	Jeanne Miecznikos	bi	1	0108	Tinno	rary Road	Ralt	imano	Marie	and 21234		
	20a. METNOD OF DISPOSITION	<u> </u>	20b. PLACE AN				bucc	20c. LOCATIO	mulga	ana 21234		
	1 Buriel 2 Cremation 3 Remo	wal from State	cemetery, crem	atory or other	placa)	Name or	DATE	20c. LOCATIO	N — City or T	own, State		
	4 Donation 6 Other (Specify) Bel Air Mem. Gdns. 7/10/95 Bel Air MD											
22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home								,	0 1	0.1 ==		
	N hall	+1			vuaa-	-kuck tun	eral H	ome of	Vunda	er, Inc.		
	10011111	MAN			7922	Wise Ave	. Dun	dalk, 1	ND 21	222		
- 1	23. PART I. Enter the diseases, pr co	proplications that ca	nused the deal	th. Do not	enter the m	node of dying, suc	ch se cardlec	or reepirator	y arrest,	Approximeta		
	shock, or hasrt failure. L.	lat only one cause	on each line.							Interval Between		
- 1	IMMEDIATE CAUSE (Finel disease or condition	111 -	4 41	1	in.	. 1 . 1 . 1 .	1 -			Onset and Death		
Į.	resulting in desth) a. Malignant Melanoma Metartatic to Brain 6 Week								6 weeks			
- 1	DUE TO (OR AS A CONSEQUENCE OF):									14		
Z	Sequentially list conditions, Due to (or As A consequence of): Due to (or As A consequence of):											
은미	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											
2 1	I II anv. leading to immediate III	2000	cause. Enter UNDERLYING									
S Cause. Enter UNDERLYING												
FIC	cause. Enter UNDERLYING CAUSE (Disease or Injury		AS A CONSEQU	IENCE OF):		that initiated events DUE TO (OR AS A CONSEQUENCE OF):						
TIFIC	cause. Enter UNDERLYING CAUSE (Disease or Injury		AS A CONSEQU	ENCE OF):								
ERTIFIC	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events		AS A CONSEQU	VENCE OF):								
- CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR			ha undadul	ng gaves glves in	Cart I au		[
	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR			he underlyl	ng ceuse given in	Part I. 24s	. WAS AN AUTO		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO		
	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR			he underlyl	ng ceuse given in				AVAILABLE PRIOR TO COMPLETION OF CAUSE		
EDICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR			he underlyl	ng ceuse given in		PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent conditions	DUE TO (OR	nth but not red	oulting in t			1	PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE		
MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent conditione DID TOBACCO USE CONTR	DUE TO (OR	ath but not red	H YES	□ NO [UNCERTA	1	PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL	DUE TO (OR	ath but not red	H YES	NO [UNCERTA	1	PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
MEDICAL	CAUSE. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	DUE TO (OR contributing to dea	SE OF DEATI	H YES	NO Check only one	UNCERTA	N 🗆	PERFORMED		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
MEDICAL	CAUSE. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	DUE TO (OR E contributing to decentributing to	BE OF DEATI	H YES OF DEATH (Check only one	UNCERTALION OF THE STATE OF THE	N	PERFORMED	0	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the 10 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be generally be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at energy.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAN



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygher prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any liniury, or other transmittenent. The medical examiner must be notified at name.

	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGII				
		Robert W.	HEN Hen			2. DATE OF DEATH MONTH July 6		3. TIME OF DEATH 31, 49p. M		
	4. SOCIAL SECURITY NUMBER 225-48-9215	1 😭 M 2 🗆 F	(In yrs. lest birthdey) 54 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year, 12/17/		BIRTHPLACE (State or Foreign Country) Virginia		
TOR	ao. FACILITY NAME (If not institution, give st Prince George Gene RESIDENCE OF DECEDENT		1	96. CITY, TOWN OR LOCATION OF DEATH Cheverly P.G. CO.						
DIRECTOR	MD Anne A	Arundel	10c, CIT	10c. CITY, TOWN OR LOCATION Brooklyn Park				10d. INSIDE CITY LIMITS? 1 YES 2 NO		
FUNERAL	15 Cedar Hill Ro		101. ZIP CODE 21225			5		S.A.		
B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	13. WAS DEC	RACE — American Indian, Black, White, etc.					
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	CATEON completed) College (1-4 or 5 +)	(Give kind of v life. Do NOT us	vork done during mose retired.)	st of working		Conct	ruction		
BE COM	17. FATHER'S NAME (First, Middle, Last) Lonnie Henso	on	COSCIUC	cion supe	16. MOTHER'S NA	ME (First, Middle, Maid fie				
TO B	190. INFORMANT'S NAME (Type/Print) Margaret A. Henso	n		ADDRESS (Stroot a	nd Number or Rural	Aoute Number, City or alto., Md	Town, State, Zip Co			
	20c. METHOD OF DISPOSITION DATE 20c. LOCATION - City or Town, State 20c. Docation - City or Town, Stat									
O AND D	Eugere	J. Cust	mh	McCu11	y Funer	al Ábme o	f Brook	lynB Balto.Md		
	23. PART i. Enter the diseases, or complications that caused the death Do not enter the mode of dying, such ea cerdiac or respiratory errest, abock, or heert fellure List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Arteriosclerotic cardiovascular disease									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
AL.	PART II. Other algolificant conditions gastric	PART II. Other algorificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. gastric ulcer 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 PART II. Other algorificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?								
PHYSICIAN: MEDIC	DID TOBACCO USE CONTR	IBUTE TO CAUSE C	OF DEATH YE		UNCERTAI	N ^X O		1 - YES 2 (N) NO		
YSIC	EXAMINER? 1 XYES 2 NO	HOSPITAL: 1 ☐ Inpetient 2 💢 ER/Outs	patient 3 DOA	OTHER: 4 - Nursing Home	5 - Residence	6 Other (Specify)				
ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	26b. TIMI INJ	URY WOI	JRY AT RK? ES 2 NO	26d. DESCRIBE HO	V INJURY OCCUR	ŧΕD		
	3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY building, atc. (Spec	/ — At home, farm, a	street, factory, office		281. LOCATION (Street end Number or Rural Route Number, City or Town, Stete)				
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC PHYSI	CIAN: To the best of my known: On the basis of examination	riedge, death occurre n and/or investigation	ed at the time, data n, in my opinion, de	end place, end due eith occured at the	to the cause(e) end r	nanner ae stated. end due to the c	ause(e) end manner ee stated.		
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Yea							uly 7, 1995		
	31. DATE FILED (Month, Dev.) Year) 1995	32. REGISTRAR'S SIGN		n ote, C	odiiip Spr	rugs, MD	40748			

j j

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should hours after death with the State Deor, of Health and Mental Hydiene prior to burial, cremation, or removal.	
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L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.	s certif	item 28 is marked or item 23 shows any injury or other trainmatic event the medical averaginer must be notified at once
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95 20964 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH HICKS ROGER 8 1995 0750 JULY 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 1950 6. AGE (In vrs. last birthday) IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR 216-54-0602 1 10 M 2 | F 45 DAYS HOURS MARCH 19 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH ANNE ARUNDEL ARUNDEL HOSPITAL NORTH GLEN BURNIE DIRECTOR RESIDENCE OF DECEDENT 10e STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND ANNE ARUNDEL GLEN BURNIE 1 YES 2 NO FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 334 GATEWATER COURT 21060 U.S.A 12 WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Maxican, Puerto Rican, stc.) 1 U YES 2 M NO Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black, White, stc. FORCES? 1 YES 2 1 Never Married 2 Married BY Specify: 3 🔀 Widowed 4 🗌 Divorced VIETNAM WHITE COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 YEARS PUBLIC WATER WORKER ANNE ARUNDEL COUNTY 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) ROBERT HICKS BE WARD 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 2 DONNA PAGE349 CONSTITUTION COURT GLEN BURNIE, MD 21061 R.20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 7<u>9</u>95 20c. LOCATION - City or Town, State 1 CBurlel 2 Cremetion 3 Removal from State cemetery cremetory or other piecel
GLEN HAVEN MEMORIAL PARK 4 Donation 8 Other (Special GLEN BURNIE, MD 21. SIGNATURE OF PUNERALS HVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME SECOND AVE. S.W. GLEN BURNIE, MD 21061 23. PART I. Entailthe disesses, or complications that caused the desth. Do not enter the mode of dying, such as cardiac or reaplratory arreat, shock, or heart feliure. List only one cause on each line. Approximate Interval Between IMMEDIATE CAUSE Final Onset and Death disesse or condition METATATIE RENAL CANCER 2 months resulting in death) DUE TO (OR AS A CONSEQUENCE OF) RENAL ENAL FAILURE
DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, if any, jesding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury MER CALCEMIA
DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL COMPLETION OF CAUSE 1 YES 2 NO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: **EXAMINER?** OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 29a, CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 2 __ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

OFFICER

103 P.

29c. LICENSE NUMBER

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SIGNATURE AND TITLE OF CERTIFIER

AYOKU 31. DATE FILED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

32. REGISTRAR'S SIGNATU Julia Dhudeson Rank

BLETUNTI.

29d. DATE SIGNED (Month, Day, Year)

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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		SETTITIONIE OF BEATTY HEG. NO.
		1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY YEAR 3. TIME OF DEATH
		Carrie Otivia Mothey July 5 1995 1.30
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) F under 1 YEAR F under 24 Hrs. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country) 7.7 Months DAYS Hours Minn. (Month. Day, Year) Country Coun
Ð		212-26-1243 1 M 2 K) 77. YRS. MONTHS DAYS HOUPES MRY. (Month. Day. Year) MAY 21, 1918 BALTIMORE, N
3 should	N.	9a. FACILITY NAME (If not institution, give street and number) FALLSTON GENERAL HOSPITAL 9b. CITY, TOWN OR LOCATION OF DEATH FALLSTON, MD 9c. COUNTY OF DEATH HARFORD CO.
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sit permit.	ERAL	100. STREET AND NUMBER 2024 MORGANSTREET 21040 UNITED STATES
020 physician. burial-transit	FUNE	=======================================
F 3 0	B	1. MAS DECEDENT EVER IN U.S., ARMED 1. Never Married 2 Married 1. Never Married 2 Married 1. YES A MAG Divorced 1. YES A MAG DATES 1. WAS DECEDENT EVER IN U.S., ARMED 1. WAS DECEDENT EVER IN U.S., ARMED 1. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— 1. RACE — American Indian, 1. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— 1. RACE — American Indian, 1. WAS DECEDENT EVER IN U.S., ARMED 1. WAS DECEDENT EVER IN U.S., ARMED 1. WAS DECEDENT EVER IN U.S., ARMED 1. WAS DECEDENT EVER IN U.S., ARMED 1. WAS DECEDENT EVER IN U.S., ARMED 1. WAS DECEDENT EVER IN U.S., ARMED 1. WAS DECEDENT EVER IN U.S., ARMED 1. WAS DECEDENTE OF HISPANIC ORIGIN? (Specify Yea or No— 14. RACE — American Indian, 15. WAS DECEDENTE OF HISPANIC ORIGIN? (Specify Yea or No— 16. RACE — American Indian, 17. WAS DECEDENTE IN U.S., ARMED 18. WAS DECEDENTE OF HISPANIC ORIGIN? (Specify Yea or No— 19. WAS DECEDENTE OF HISPANIC ORIGIN? (Specify Yea or No— 19. WAS DECEDENTE OF HISPANIC ORIGIN? (Specify Yea or No— 19. WAS DECEDENTE OF HISPANIC ORIGIN? (Specify Yea or No— 19. WAS DECEDENTE OF HISPANIC ORIGIN? (Specify Yea or No— 19. WAS DECEDENTE OF HISPANIC ORIGIN? (Specify Yea or No— 19. WAS DECEDENTE OF HISPANIC ORIGIN? (Specify Yea or No— 19. WAS DECEDENTE OF HISPANIC ORIGIN? (Specify Yea or No— 19. WAS DECEDENTE OF HISPANIC ORIGIN? (Specify Yea or No— 19. WAS DECEDENTE OF HISPANIC ORIGIN? (Specify Yea or No— 19. WAS DECEDENTE OF HISPANIC ORIGIN? (Specify Yea or No— 19. WAS DECEDENTE OF HISPANIC ORIGIN? (Specify Yea or No— 19. WAS DECEDENTE OF HISPANIC ORIGIN? (Specify Yea or No— 19. WAS DECEDENTE OR HISPANIC ORIGIN? (Specify Yea or No— 19. WAS DECEDENTE OR HISPANIC ORIGIN? (Specify Yea or No— 19. WAS DECEDENTE OR HISPANIC OR HISPAN
215 attend use as	0	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working
5 8 5	- E	Elementary/Secondary (0-12) College (1-4 or 5+)
AND the hospital detached for	2 Z	n/a HOUSE WIFE DOMESTIC
	COMP	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame)
	BE	DENNIS WILLIAMS SR. MARGARET KELL
MAR retained 5 should	TO BE	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2 8	9	MORRIS HOLLEY 2 ORION COURT, BALTIMORE, MD 21237
MOR le 6 ma rector, p	H H	20a, METHOD OF DISPOSITION 1 Description Date D
	examiner	21. SIGNATURE OF FUNERAL SERVICE LICENSEE
m - = @		S. Valencia Holland WM. C. MARCH FH1101 E. NR. AVENUE
In by	medical	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or haert fallure. List only one cause on each line. Approximate interval Between
Alled on or	E	IMMEDIATE CAUSE (Final Onset and Des
tely mattic	<u>.</u>	disease or condition resulting in death) - SEPSIS / DAY
760 nd will omple d, cre	679	OUE TO (OR AS A CONSEQUENCE OF):
58 ecute and c	N S	Sequentially list conditions, b. ACUTE PYEZO NEPH RITIS 1 DAY
be es	y, or other traumatic	If any, leading to immediate
certificate ding physical sygiene pri		CAUSE (Disease or injury
Serie Co	E	that initiated eventa resulting in death) LAST //SVLIN OFFENDENT DIABETES MELLITUS 5 FARS
	CER OF	0
	AL CE	PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY PINDING
7 5 8 5	MEDICAL	CEREBROVASCULAR ACCIDENT PERFORMED? AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATHS
Thealth	ME	OF DEATH?
		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN
The law rite has a ste Depri	SICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE QF DEATH (Check only one)
SICIAN: The certificate the State	YSIC	HOSPITAL: 1 YES 2 WO OTHER: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)
HYSICIA with the		27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DE\$CRIBE HOW INJURY OCCURED
P F F F F F F F F F F F F F F F F F F F	BY Pt	1 Netural 5 Pending 2 Accident Investigation M 1 YES 2 NO
NDING I	ا م ا	3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, farm, street, factory, office 28f. LOCATION (Street and Number or Rural Route Number,
	TEI 28	4 Homicide determined City or Yown, State)
B B B	F 18	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.
THE HOSPITAL THE FUNERAL filed within 72 I	COMPLETE	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
With With	S	29b, SIGNATURE AND TITLE OF CERTIFIER
TO THE HOSPI TO THE FUNER be filed within	BE	Harden Nowalismal un D08096 200. LICENSE NUMBER D08096 JULY 5, 1995
F F Å	일	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
		Fallston General Hosp. Fallston, MD
		31. DATE FILEO (Month, Day, Year)
		MI 2 1995 On lan or water handall

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DIVISION OF VITAL	

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE	TE OF MARYLANI) / Depar	RTMENT OF H	EALTH AND	MENTAL HYGIEN	E	60540	
	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)		CERTIF	ICATE OF	DEATH	REG. NO.	NY.	YEAR 3. TIME OF DEATH A	
	FRANCT 4. SOCIAL SECURITY NUMBER 5. SEX		HELLE HARRINGTON 17 yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.			JULY 7. DATE OF BIRTH	8,199	8. BIRTHPLACE (State or Foreign	
	217-68-2282 1 M	2XXF 36	YRS.	MONTHS DAYS	HOURS MIN.	SEPT.18,		BALTIMORE, MD	
TOR	1523 E. 28	TH STREET	ľ		TIMORE	CITY	9c. COUN	n/a	
DIRECTOR	10a, STATE 10b, COUNTY	_	10c. CIT	Y, TOWN OR LOCAT	ION TIMORE			10d. INSIDE CITY	
	MARYLAND n/s	a			ZIP CODE		10g. CITIZ	YES 2 NO EN OF WHAT COUNTRY?	
FUNERAL	1523 E. 28	TH STREE			21218		UNI	TED STATES	
BY FUI	NON Never Married 2 Married FOR	DECEDENT EVER IN U.S. CES? 1 YES 2 ES, GIVE WAR OR DATES	ARMED	If yes, sp		NIC ORIGIN? (Specify Yes in, Puarto Ricari, etc.) y:	or No—	14. RACE — American Indian, Black, Whita, atc. Specify: BLACK	
B	15. DECEDENT'S EDUCATION (Specify only highest grade completed	16e	DECEDENT'S	USUAL OCCUPATION	NA	16b. KINO OF BUS	SINESS/INOU		
COMPLETED		(1-4 or 5 +)	unemp	se retroct.)	a or warring		never	worked	
BE CON	C. FATHER'S HAMP (S) OF MICHOL LAND HARRIN	18. MOTHER'S NA	ME (First, Middle, Melden ARETHA C	Sumame) OSBY					
TO 8	194. HECHMANT'S NAME (TypesPrint) ANNIE COSBY		196. MAILING 152			STREET, BA		Code) ORE,MD @!@18	
	204 METHOD OF DISPOSITION **Pourisi 2	State 206 PLA	CE AND DATE OF	of disposition (No ther giace) WN CEME		1		Ity or Town, State	
	22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH1101 E. NORTH AVE.								
	23. PART I. Enter the diseases, or complice abook, or heart failure. List only IMMEDIATE CAUSE (Final	one cause on each i	line.		de of dying, auc	h aa cardiac or reapi	ratory arre	at, Approximate Interval Between Onset and Death	
	disease or condition reaulting in death)	DUE TO (OR AS A CON	CONSEQUENCE OF:					1 day	
N	- HIV infection								
ATIC	if any, leading to immediate	emento	SECUENCE OF	F):				5 moth	
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	OUE TO (OR AS A CON		F):				S MONTA	
- 1	PART ii. Other algnificant conditions contril	outing to death but no	ot reauiting	in the underlying	cause given in	Part I. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS	
MEDICAL						1 TYES 2		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
	DID TOBACCO USE CONTRIBUTE	TO CAUSE OF D	FΔTH YE	S 🗆 NO 🔯	UNCERTAIN			1 TYES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. P		TH (Check only one)	ONCERIAII			J	
IXSI	1 YES 2 2010 1 Inp	itlant 2 - ER/Outpatien				8 Other (Specify)			
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	28b. TIM INJ	URY WO	JIRY AT RK? ES 2 NO	28d. DESCRIBE HOW INJURY OCCURED				
8		home, ferm, s	street, factory, office	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINED OF THE								
- 1	2 MEDICAL EXAMINER: On the	beals of examination and	or investigation	n, in my opinion, d	29c. LICENSE NUR				
TO BE	Charles Itohi	M2)		D4	1116	▶ 7	SIGNED (Month, Dey, Year)	

Greene St., Balto

30. NAME AND ADDRESS OF PEN Charles
31. DATE FILEO (Month, Day, Year)
JUL 1 2 1995

HO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

nson

32 REGISTRAR'S SIGNATURE

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3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign

Maryland

10d. INSIDE CITY

14. RACE — American Indian, Black, White, atc.

Black

21207

1 X YES 2 NO

n/a

USA

Specify:

6:30 PM

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DALLIMONE, MANTLAND 21213-002	s executed within and hours after death. Page 6 may be retained by the hospital or attending phy	in and completely filled in by the funeral director, page 5 should be detached for use as the bur to burial, cremation, or removal,
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AM.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 death certificate be AL DR ATTENDING PHYSICIAN: The law
A DIRECTOR: After this certificate has
2 hours after death with the State Dep
I litem 28 is marked, or item 23 TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH Johnson <u>Melvin Norwood</u> July 10. 1995 5. SEX 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) DAYS 1 M 2 🗆 HOURS MIN. May 7, 218-22-9043 66 1929 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 5518 Peerless Avenue Bal.timore 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION Maryland n/a Baltimore 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 5518 Peerless Avenue 21207 12: WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yee, specify Cuban, Maxican, Puerto Rican, etc.)

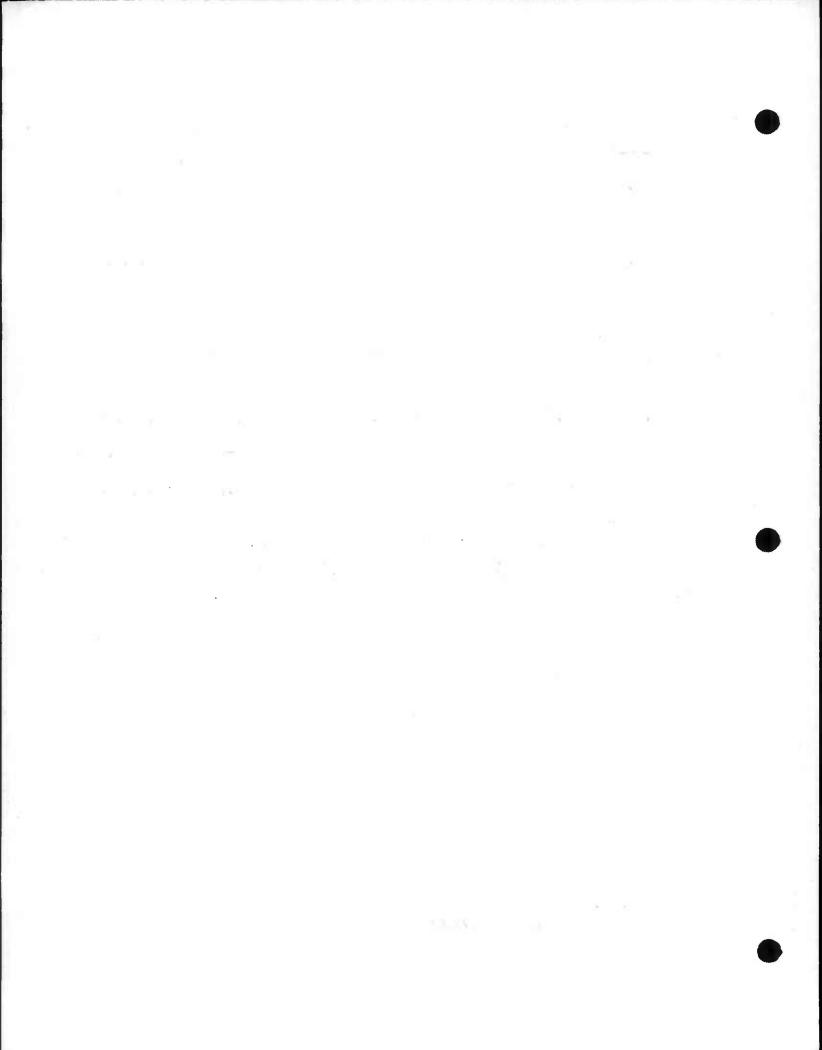
1 YES 2 NO Specify: 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION pecify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (0-12) College (1-4 or 5+) Grade School Track Inspector Amtrack 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Samuel Johnson Mary Viola Williams 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5518 Peerless Avenue Dorothy M. Johnson Baltimore, Maryland 20a. METHOD OF DISPOSITION
1 ◯ Burlal 2 ◯ Cremation 3 ◯ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of July 20c. LOCATION — City or Town, State cometery, cremetory or other place) Saints Rest Cemetery 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Terbera Baltimore, Maryland shock, or haert failure. List only one ceuse on eech line. IMMEDIATE CAUSE (Finel disease or condition DUE TO (OR AS A CONSCOPENCE OF) resulting in death) hear Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I.

Harmons, Maryland 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximata Interval Between **Onset and Death** years CERTIFICATION MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? inout wiener 1 | YES 2 | NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN Q PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 TYES 2 WHO Inpetiant 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending BY 1 YES 2 NO 2 Accident 3 Suicide 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 🗌 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(e) and manner as stated. the beals of axamination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 296. SUDNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE conjuna 19823 2 MPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 40 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

FUNERAL I HOSPITAL

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		FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	TMENT OF H	EALTH AND M	ENTAL HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Last) CATHERINE W. J	OHN		-		2. DATE OF DEATH	995 YEAR	3. TIME OF DEATH 9:00 A .M	
70		4. SOCIAL SECURITY NUMBER 212-36-1873	5. SEX 6. AGE ((in yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year) March 28.	8. BIF	ATHPLACE (State or Foreign unity) Maryland	
2, 3 should	COMPLETED BY FUNERAL DIRECTOR	412 S. Robinson				ore City		9c. COUNTY OF	THE RESERVE TO THE PARTY OF THE	
. Pages 1,		RESIDENCE OF DECEDENT 106. STATE 106. COUNT Maryland N/A	Y		timore	ION			10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
nsit permit		100. STREET AND NUMBER 412 S. Robinson	Street			. ZIP CODE 21224		10g. CITIZEN OF	F WHAT COUNTRY?	
the burial-transit permit. Pages 1,		11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, OIVE WAR OR DO	2X NO	If yes, spi	ENDENT OF HISPANIC ocity Cuben, Mexicon, 2 NO Specify:	ORIOIN? (Specify Yes Puerto Rican, etc.)	BI	ACE — American Indian, lack, Whita, atc. Decity: White	
d for use as		(Specify only highest grade completed) (Give kind life. Do NC life								
d be detached	BE COM	2nd Hous 17. FATHER'S NAME (First, Middle, Last) Unknown Gunther			11.6	18. MOTHER'S NAME Unkn	N/A AME (First, Middle, Malden Surneme) CHOWN			
be notified	TO B	Mrs. Eugenie M. 1		412 S	. Robins	son Stree	t, Baltimo		21224	
director, p		20y: METHOD OF DISPOSITION 1	G	petery, cremetory or oth Len Haven	Memoria	al Park				
the funeral divoval.	22. NAME AND ADDRESS OF FACILITY Matthews Funeral Home 3021 Eastern Ave., Baltimore, Md. 21 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Applications and the death.								Md. 21224	
Special and completely filled in by the funeral director, page 5 should be detached prior to burial, cremation, or removal. Traumatic event, the medical examiner must be notified at once.	CATION	shock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Inlury	a. Due 10 on As A	ech iine.	Heart				Approximete Interval Between Onset and Daath Liming 10 ym	
y the attending physician a digital Mental Hygiene prior to Injury, or other traum.	CERTIFI	that initiated events resulting in death) LAST	d	A CONSEQUENCE OF):						
ealth and we amy I	MEDICAL	PART II. Other algorificant condition	e contributing to deeth b	eas 2	Seary	ceuse given in Pa	24a. WAS AN PERFOR	MED?	4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
Dept. of	SICIAN: N	DID TOBACCO USE CONT. 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		F DEATH YES		UNCERTAIN			1 YES 2 NO	
the the	PHYSIC	1 VES 2 NO 27. MANNER OF OEATH	HOSPITAL: 1 Inpetient 2 ER/Outp 28e. DATE OF INJURY (Month, Day, Yeer)		OF 28c, INJU		Other (Specify)	JURY OCCURED		
after death with 28 is marked	ED BY	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, atc. (Spec	- At home, farm, str	M 1 🗆 Y	ES 2 NO	81. LOCATION (Street e. City or Town, State)	nd Number or Rura	al Route Number,	
2 hours	COMPLETE	29e. CERTIFIER (Check only 1 CERTIFYINO PHYSI	CIAN: To the best of my knowl R: On the beels of exemination				the cause(e) and men			
IN THE PUNEIVAL be filed within 72 ? IMPORTANT: If I	#	29b. SIGNATURE AND THILE OF CENTIL OF	(12.14	~ P	, in my opinion, od	29c. LICENSE NUMBE			ED (Monts, Day, Year)	
- 6 =	5	30. NAME AND ADDRESS OF PERSON WH	TORNES	5, MD	Prine) 444 <	5. Ellu	ood Au	it Bat	K, MD 21229	
		31. DATE [1 2 1995 J	1. Missilar dise	处战						



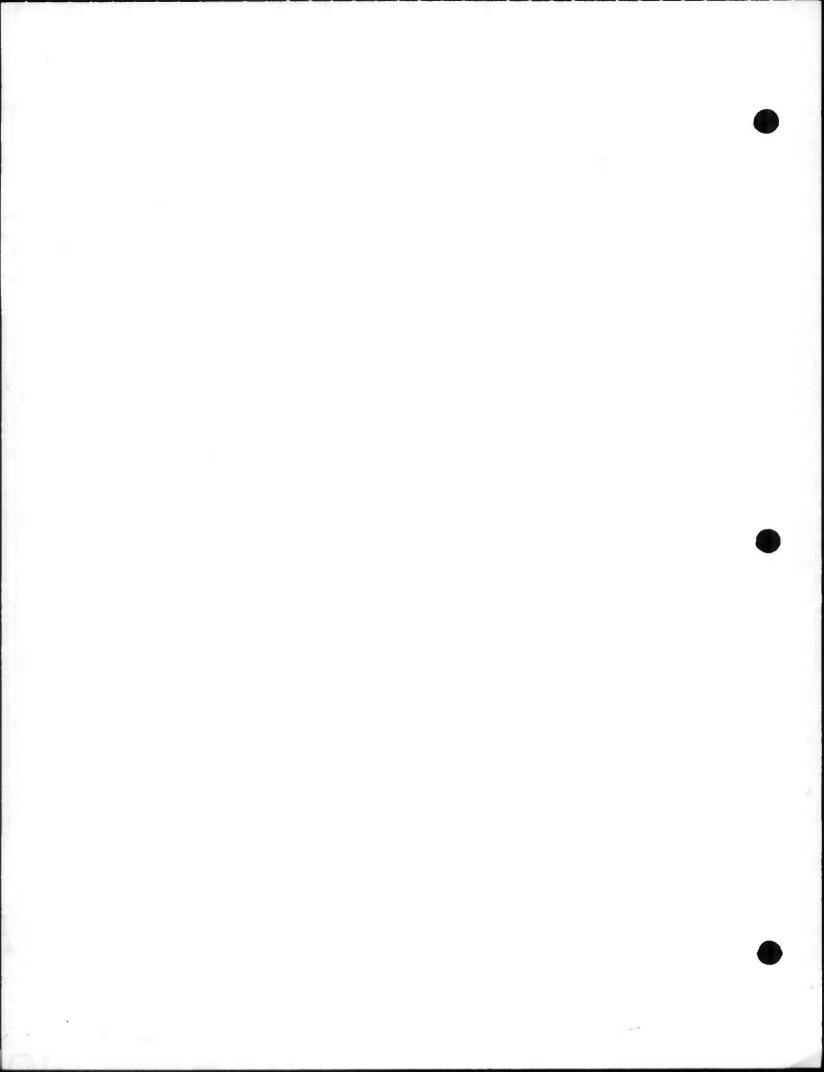
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages in	be filed within 72 hours after death with the State Dept. of Health and Mertal Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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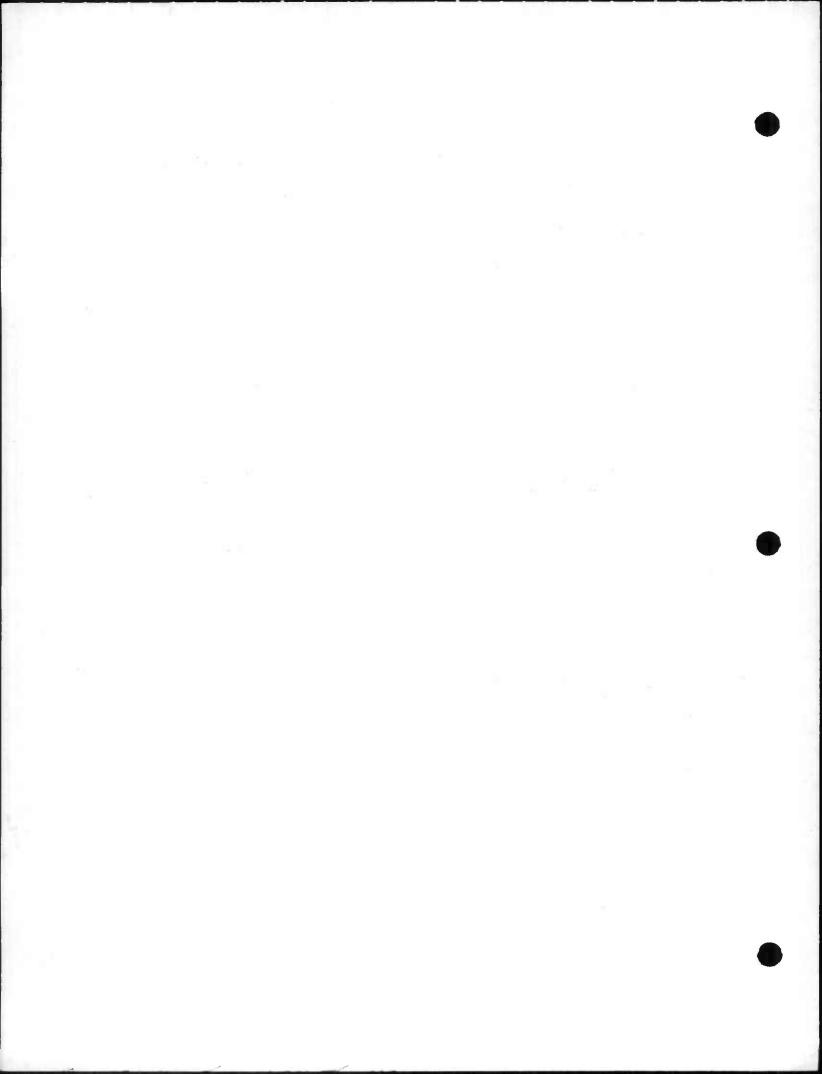
	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
- 3	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH 3. TIME OF DEATH			
	Earl	Koser			MONTH D	9 4	5 11:20 a M	
	and the second second	SEX 6. AGE (In yrs. I	est birthday) IF UND	ER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BI	RTHPLACE (State or Foreign puntry)	
1	210-01-7032	X M 2 D F 85	YRS.	DAYS HOURS MIN.	June 13		NorthCarolin	
~	Sa. FACILITY NAME (If not institution, give stree.	and number)	9b. CF	TY, TOWN OR LOCATION OF E	EATH	9c. COUNTY O	F DEATH	
0	Liberty Medical Center Baltimore NA							
EC	10a. STATE 10b. COUNTY		10c. CITY, TOWN	OR LOCATION			10d, INSIDE CITY	
PHO	MD	NA	Balti				LIMITS?	
AL	10e. STREET AND NUMBER	NA .	I Dalle	101. ZIP CODE		10g. CITIZEN C	OF WHAT COUNTRY?	
FUNERAL DIRECTOR	301 Mc Mechen	СT		21217		USA		
2	11. MARITAL STATUS 13	PORCES? 1 YES 2	RMED 13	. WAS DECENDENT OF HISPA		or No- 14. R	ACE — American Indian,	
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced FORCES? 1 YES 2 JAO IF YES, GIVE WAR OR DATES			1 ☐ YES 2 ☑ NO Specify: Specify:			lleck, White, etc. pecify:	
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0	12 cd. 4 yrs. rns. Broker Ins. Company 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Melden Surneme)							
BE C	James Koger Maggie Graves							
TO B	19a. INFORMANT'S NAME (Type/Print)	1	9b. MAILING ADDRE	SS (Street and Number or Rura		n, State, Zip Code)	
F	Thelma Parker		2901 18	th St. nw	apt.505			
	20a. METHOD OF DISPOSITION 1 Burlet 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	20b. PLACE	AND DATE OF DISPO			CATION — City o		
			Itus Cer	neterv	7 2 19 Bal	timore	MD	
	22. NAME AND ADDRESS OF FACILITY							
	4600 Liberty Hgts. Ave.							
	23. PART i. Enter the diseasea, or corr shock, or heart failure. List	plications that caused the d	leath. Do not ente	r the mode of dying, su	ch as cardiac or reap	iratory arreat,	Approximate interval Between	
	IMMEDIATE CAUSE (Finel							
	disease or condition resulting in death) a. Phenmonis							
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF):							
	Sequentielly list conditions, if any, leading to immediate	DUE TO (OR AS A CONSI	Pespitory failure. TO (OR AS A CONSEQUENCE OF):					
CAT	cause. Enter UNDERLYING	Diabetic mellins						
Ė	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONSEQUENCE OF):						
H	reaulting in death) LAST	Commany attery disease.						
AL C	PART II. Other aignificant conditions of	ontributing to death but not	resulting in the u	inderlying ceuse given in	Pert i. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS	
S	Atnal	hornligt			PERFOR	IMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
	Rengi	failure			1 🗆 YES 2	P-NO	OF DEATH?	
7	DID TOBACCO USE CONTRIB		ATH YES	NO UNCERTAL	N \square		1 YES 2 NO	
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)							
SIC	the same of the sa	OSPITAL: ☐ Inpatient 2 X ER/Outpatient	3 DOA 4 N	R: Insing Home 5 🗆 Residence	6 Other (Specify)			
PH	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW I	NJURY OCCURED		
BY	1 Netural 5 Pending 2 Accident Investigation		М	1 YES 2 NO		_		
	3 Suicide 6 Could not be 4 Homicide determined				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
COMPLETED	A PRODUITE A							
F	29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.							
S	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated.							
BE (296. SIGNATURE AND TITLE OF CERTIFIER	10.11	te ne	29c. LICENSE NU	MBER	29d. DATE SIGN	IED (Month, Day, Year)	
2	TO MANY AND ADDRESS OF		9 Phys	CUSU D3	0115	> 7	795	
	- 41	0. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)						
	31. DATE FILED (Month) Day Year)	491, mo 2600 LIBERTY HATS AVE BAILY, MB 2/2/5.						
		Judge Finlet		- Land				



BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	L DIRECTOR: After this conflictate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
DIVISION OF VITAL RECORDS, P.O. BOX 68760	L DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-24 hours after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First,	Middle, Last)				IOAIL	- 0.	DEA	-	2. DATE OF	DEATH			3. TIME OF DEATH
		Walter	11040 001		Koppe	1man	Ir				July	DA	1995	YEAR	6:35pm M
		4. SOCIAL SECURITY NUMB	ER	5. SEX	8. AGE (In yrs. Ia				IF UNDER	24 HRS.	7. DATE OF 6	BIRTH	1993	S. BIRTHP	LACE (State or Foreign
	OR	216-09-689	12	1 🔀 M 2 🗌 F	79	YRS.	MONTHS	DAYS		MIN.	Nov	by Many)	1915	Country)	yland
permit. Pages 1. 2, 3 should		9e. FACILITY NAME (if not institution, give street end number)					9b. CITY,	Ib. CITY, TOWN OR LOCATION OF DEATH Sec COUNTY OF					,		
60		2201 Chapel Valley Lane						Lut	hervi	i 11e			B	altir	nore
1.2	5	RESIDENCE OF DECEDENT												are in	HOLC
Pages	DIRECTOR	10e. STATE	10c. CIT	10c. CITY, TOWN OR LOCATION							1	IOd. INSIDE CITY			
THE .		Maryland 100. STREET AND NUMBER			Lutherville								YES 2 X NO		
<u>8</u>	RA			101. ZIP CODE						10g. CITE	ZEN OF WH	IAT COUNTRY?			
physician. burial-transit	FUNERAL	2201 Chape	·I Val		NT EVER IN U.S. AF					2109					USA
physician. burial-trar		1 Never Merried 2 🔀	Merried	FORCES?	YES 2	NO If yes, specify Cuben, Mexicen, Pue					n, Puerto Ricer	pecify Yee n, atc.)	or No —	Bleck,	- American Indian, White, etc.
ding the	B	3 Widowed 4 Divo	WWII	1 YES 2 NO Specify:				:			Specify:	White			
the hospital or attending detached for use as the once.	9		EDENT'S EDUC		16a, DE	ECEDENT'S USUAL OCCUPATION Bive kind of work done during most of working					16b. KIN	D OF BUS	SINESS/IND	USTRY	
al or for u	COMPLET	Elementary/Secondary (0		College (1-4 or 5	III.	. Do NOT u	se retired.)		TOST OF WORKIN	ig.					
the hospital detached fo	₩ ₩	12		1		Rea.	nerci Ltor	aı				Rea1	Esta	te	
-	8	17. FATHER'S NAME (First, MI		16. MOTNER'S NAME (First, Middle, Maiden Surname)											
PA PA	H	Walter			Koppe1ma					Grace				inder	dale
retained 5 should notified	2	19a. INFORMANT'S NAME (7)		_	19						loute Number, (
2 8 .		Mrs. Barbar		opelman						ey La					21093
death. Page 6 may be funeral director, page examiner must be		1 Donation 5 Disposition	n 3 Reme	oval from State	20b. PLACE cemetery, cre	emetory or o	ther place!		Vame of		006			City or Town	
direct direct	1	Q1. SIGNATURE OF THEMPA	1	ENDE	Metr	o Cr	emato		AND ADDRES	SO OF EAC	July	Car	tonsv	ille	, MD
death. Pag tuneral dii I. examiner	III	* Jours	- 20	1	uno		/ /				ral Ho	me			
		Loweld M. Lemmon 10 W. Padonia Road, Timonium, MD 21093											MD 21093		
hours after of in by the or removal.	П	23. PART I. Enter the di shock, pr he	seesaa, or c	omplications the	et caused the de	eath. Do i	not anter	the m	ode of dyl	ng, such	aa cardlec	or respli	ratory arre	eet,	Approximate interval Between
y filled in tition, or the me		ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final													Onset and Death
thely i matio		disease or condition reaulting in death)	→	. Met	as tati	- +	2005	ten f	te C	91	ces				18mon
omplete d, crema		DUE TO (OR AS A CONSEQUENCE OF):													
e be executed within 24 in sician and completely filled infor to burial, cremation, of traumatic event, the r	S	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):													
	CERTIFICATION	If any, leading to immade cause. Enter UNDERLY!		DOE TO	(OH AS A CONSE	DUENCE O	ve or j.								
e by	윤	CAUSE (Disease or inju		DUE TO	(OR AS A CONSE	OUENCE O	F):								
h cert Aygie Or ot	E	that initiated eventa DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST													
deat artic		PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS													
m 60 -	DICAL	PART II, Other aignifice	nt condition			reeuiting	in the un	derlyln	ng ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED?				FERE AUTOPSY FINDINGS		
= 2 5 8	ă	Coronas	7 14	1	1 scasc							COMPLET			OMPLETION OF CAUSE OF DEATH?
0 5 5 5	ME	Cervica	\sim	ondy	lesis					_				1	☐ YES 2 ☐ NO
law Dept.	A N	DID TOBACCO US		RIBUTE TO CA				_		ERTAIN	1 🗆 📗				
Sician: The law re certificate has been the State Dept. of, or Item 23 si	PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:			OTHER		"						
ician icertifican	₹	1 YES 2 NO		1 Inpatient 2	ER/Outpatient 3	-				sidence i	8 Other (Sp				
NG PHYS fter this c eath with marked,		F-1	Pending	(Month, E		28b. TIM INJ	JURY	W	ORK?	140	28d. OESCRIE	BE HOW IN	NJURY OCC	UREO	
After death	BY	2 0 0 1 1 1 1	nvestigation	28e. PLACE C	OF INJURY — At he	me farm	etraat facto		YES 2	JNO	ORI LOCATIO	AL (Day of a		0 10	
L DR ATTENDING P DIRECTOR: After ti hours after death v item 28 is mark			Could not be letermined	building,	etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		ny, om			28f. LOCATIO City or To	wn, State)	na number	or nurer not	ne numoer,
DIREC Hours	E	29e. CERTIFIER	TVINO BUVOU			200		_				Cx 1 level 3	1111111111		
RAL TAL	COMPL			CIAN: To the best of											nd manner ee stated.
TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law TO THE FUNERAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dept. IMPORTANT: If Item 28 is marked, or Item 23	8						, m my 01	JIIIOI1, 1				prace, enc	a que to the	e ceuse(e) e	ind manner ee stated.
五	핆	296. SIGNATURE AND TITLE	OF CERTIFIER	M	1 am-	101		1	29c. LICE	NSE NUM	BER				forth, Day, Year)
2 6 3 S	임	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CALL	SE OF DEATH OTE	M 27) /5/0-	Drint1		1/	1990	امرا		J	uly (1995
								rei	+17 D1.	T.TT?	aud to	. 10	D - 1	4.0	MD 01010
1		William D. 31. DATE FILED (Month Day)	ONE OF	32010	ne handall	VV	MITAG	TST	Ly FK	wy.,	Sulte	: 16,	, bal	το.,	rw. 21210
10		JUL 1 2 19	מט אל												



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DIVISION OF VITAL RECORDS, P.O. BOX 68760

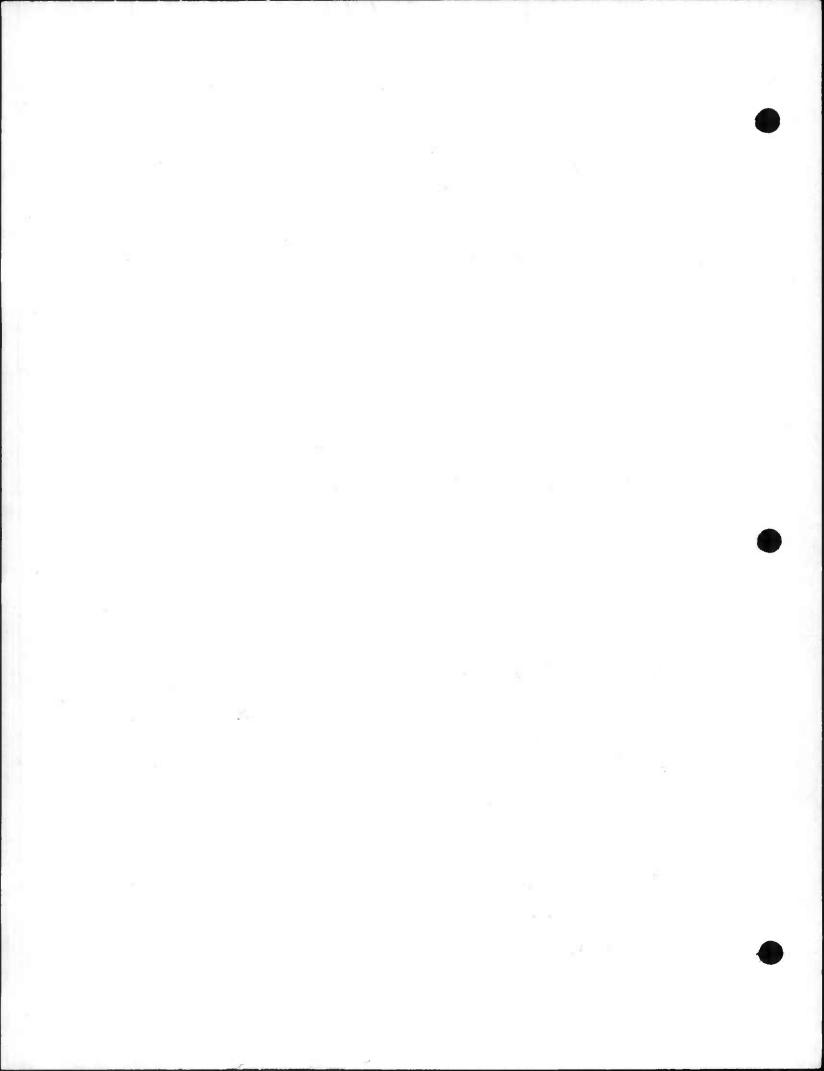
	5,	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 2 hours after death with the State Derd. of Health and Mental Hodere prior to burial, cremation, or removal.	MPORTANE It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event. The medical examiner must be notified at once
equires that the death certificate be executed within 24 hours after death. Page 6 may be retained	igned by the attending physician and completely filled in by the funeral director, page 5 should the fath and Mental Hydiene prior to burial, cremation, or removal	hows any injury, or other traumatic event, the medical examiner must be notified
The law	ate has b	lem 23
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 Lois Lucero July 6:00 A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birtnday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 278-32-4598 HOURS DAYS 1 M 2 X F 63 Aug 24, Ohio 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF OFATH 9c. COUNTY OF DEATH Howard County General Hospital Columbia Howard DIRECTOR RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10e. STATE 10b. COUNTY 10d. INSIDE CITY LIMITS? MD Columbia Howard 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 10630 Green Mountain Circle 21044 USA 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexicen, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIYE WAR OR DATES 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married if yes, specify Cuben, Mexicen, Puerto Ricar 1 ☐ YES 2 📉 NO Specify: BY 3 Widowed 4 Divorced White COMPLETED 15. OECEDENT'S EOUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) 12 Homemaker Own Home 5+ 17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Robert C. Renner Fay Sowry BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Eddie Lucero 10630 Green Mountain Circle, Columbia MD (Spouse) 21044 20a, METHOD OF DISPOSITION
1 M Burtel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State July Columbia Men. Park ☐ Donation 5 ☐ Other (Specify) _ 13, 1995 Clarksville, MD 21. SIGNATURE OF EMPERAL BERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Leroy & Russell Witzke Funeral Home usura 5555 Twin Knolls Rd. Columbia, MD 21045 23. PART i. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, Approximata shock, or heert failure. List only one cause on each line. interval Betw **IMMEDIATE CAUSE (Fine) Onset and Death** disease or condition___ Pneumonia 2 Days resulting in death) QUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate e. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART ii. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMEO? MEDICAL Degenerative Neurologic Disorder 1 TYES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 🗵 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 TES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Suicide 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide determined 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated. 2 MECICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month Day Year) 띪 Ste D 34613 July, 9 1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Steven Geller M.D. 9501 Old Annapolis Road Ellicott City, MD 21042

31. DATE FILED (Month, Day, Year)

32. REGISTRAR'S SIGNATURE



ITEMS: 7. & 20b, PER F.H. FILM G-725 7/12/95 t.t

95 20952

		1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPAR CERTIF	TMENT OF HEALTH AND ICATE OF DEATH	MENTAL HYGIEN REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last) ROBERT LE		MAYO III	2. DATE OF OEATH MONTH DA	AY YEAR	TIME OF DEATH
			. SEX 6. AGE (in yrs. lest birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH 1	975 8. BIRTHPL	12:00 PM. ACE (State or Foreign
꾴			(XM2 □ F 19 YRS.	MONTHS DAYS HOURS MIN.	SEPT. 14	1975 MD	
3 should	E	90. FACILITY NAME (If not institution, give street UNIVERSITY S.T.		BALTIMORE CI		0c. COUNTY OF DEAT	Н
1, 2,	ЕСТОВ	RESIDENCE OF DECEDENT			11		
permit. Pages 1,	DIRE	10a. STATE 10b. COUNTY		Y, TOWN OR LOCATION ALTIMORET		10	d. INSIDE CITY LIMITS? YES 2 NO
permit		10e. STREET AND NUMBER		101. ZIP CODE		10g. CITIZEN OF WHA	Λ
asit.	FUNERAL	11 MARITAL STATUS	He St.	2120	1	USA	
21215-0020 al or attending physician for use as the burial-tra	BY FU	1 Never Married 2 Merried 3 Widowed 4 Divorced	2. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPAI If yes, specify Cuben, Mexice 1 YES 2 NO Specify	n, Puerto Rican, etc.)	s or No— 14. RACE — Black, W Specify:	American Indian, /hile, etc.
215 attend use as	9	15. DECEDENT'S EDUCAT (Specify only highest grade con		USUAL OCCUPATION work done during most of working	16b. KIND OF BUS	SINESS/INDUSTRY	DINOR
14 m 5	PLET	Elementary/Secondary (0-12)	College (1-4 or 5+) Iiie. Do NOT us	no retired.)	N	A	100
YLAND 212 by the hospital or att be detached for use at once.	COMPL	7. FATHER'S NAME (First, Middle, Last)		1	ME (First, Middle Maiden	Surneme)	
Z 22 #	BE (KOBERT LEE MY	tyo Je.	GERA	Lyn Bo	DONE	
MARYLAND retained by the hospit s should be detached notified at once.	2	190. INFORMANT'S NAME (Type/Prim)	196. MAILING	ADDRESS (Street and Number or Rural	Route Number, City or Town	n, State, Zip Code)	1216
E ag P		26e METHOD OF DISPOSITION 1 A Burlai 2 Commetten 3 Hemove	from State 20b PLACE AND DATE O		DATE 20c. LOC	CATION — City or Town,	State
IMO Page 6 directo		4 Donation 5 Dither (Specify)	BULL KIN		17-13-14 D	alto M	d
BALTIMOR after death. Page 6 ma by the funeral director, in noval.		• M	B 1 - a 04	Hageh tung	al Home-	wost,	51512
BA after of by the moval.	\vdash	23. PART I, Enter the diseases, or com	plications that caused the death. Do n	ot enter the mode of dying, auc	h as cardiac or respir	ratory arrest.	Approximate
B o B		IMMEDIATE CAUSE (Final	t only one causelon each line.				Interval Between
the matrix		disease or condition resulting in death) e	MULTIPLE GON DUE TO (OR AS A CONSEQUENCE OF	SAUNDS TOHS	WHIH COM	APLICATION	2
B 5 - 6	z		DUE TO (OH AS A CONSCOUENCE OF	-):			
De ex or to a sum	RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSEQUENCE OF	7):			
ficat phy de r	IFIC	CAUSE (Disease or Injury that initiated events	OUE TO (OR AS A CONSEQUENCE OF	ŋ:			
요 등 등 등	CERT	resulting in death) LAST					
DS the d we will we will be do		PART II. Other significant conditions of	ontributing to death but not resulting in	n the underlying ceuse given in	Part i. 24a. WAS AN. PERFOR		RE AUTOPSY FINDINGS AILABLE PRIOR TO
COR es that gned by salth an	MEDICAL				1 XYES 2	CO.	MPLETION OF CAUSE DEATH?
Mercolous manuscript of Health a shows any 3 shows any		DID TOBACCO USE CONTRIB	SUTE TO CAUSE OF DEATH YE	S NO M UNCERTAIN	'	1	YES 2 🗆 NO
ATAL F N: The law r ficate has be State Dept. Item 23 s	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF DEAT	H (Check only one)	· U		
a the CA	IYSI	1 X YES 2 NO 1)		OTHER: 4 Nursing Home 5 Residence			
NG PHYSI fler this c eath with marked,		1 Netural 5 Pending	280. DATE OF INJURY (Month, Day, Year) JUNIE 13, 1995		34 B TO + S	SHOT	
VISION ATTENDING F ECTOR: After 's after death A 28 is man	ED BY	3 Suicide 8 Could not be	28e. PLACE OF INJURY — At home, ferm, a building, etc. (Specify)		281, LOCATION (Street e City or Town, State)	and Number or Rural Route	Number, MD
DIVISION OR ATTENDING F DIRECTOR: After thours after death item 28 is mar	E	An account		265TAURANT	764 W. BAI		BAUTIMORE
PITAL (COMPLET	(Check only	N: To the best of my knowledge, death occurre on the beste of examination and/or investigation				d menner se stated
E HOSPITAL E FUNERAL 3 within 72 1		294 SIGHATURE AND TITLE OF GERTIFIER	TO COLOR	29c. LICEMSE NUM		29d. DATE SIGNED (Mo	
TO THE HOSPITAL TO THE FUNERAL De filed within 72 is	TO BE	Sund	DOLL AI W	O.C.M		JULY 7	
		MARIO F GOLVE T	W Muss				
		31. DATE FILED (Month, Day, Year)	32_REGISTRAR'S SIGNATURE	nn Street, Ba	Itimore,	Maryland	1 21201
		JUL 1 2 1995 Sul	devolor harlall				İ

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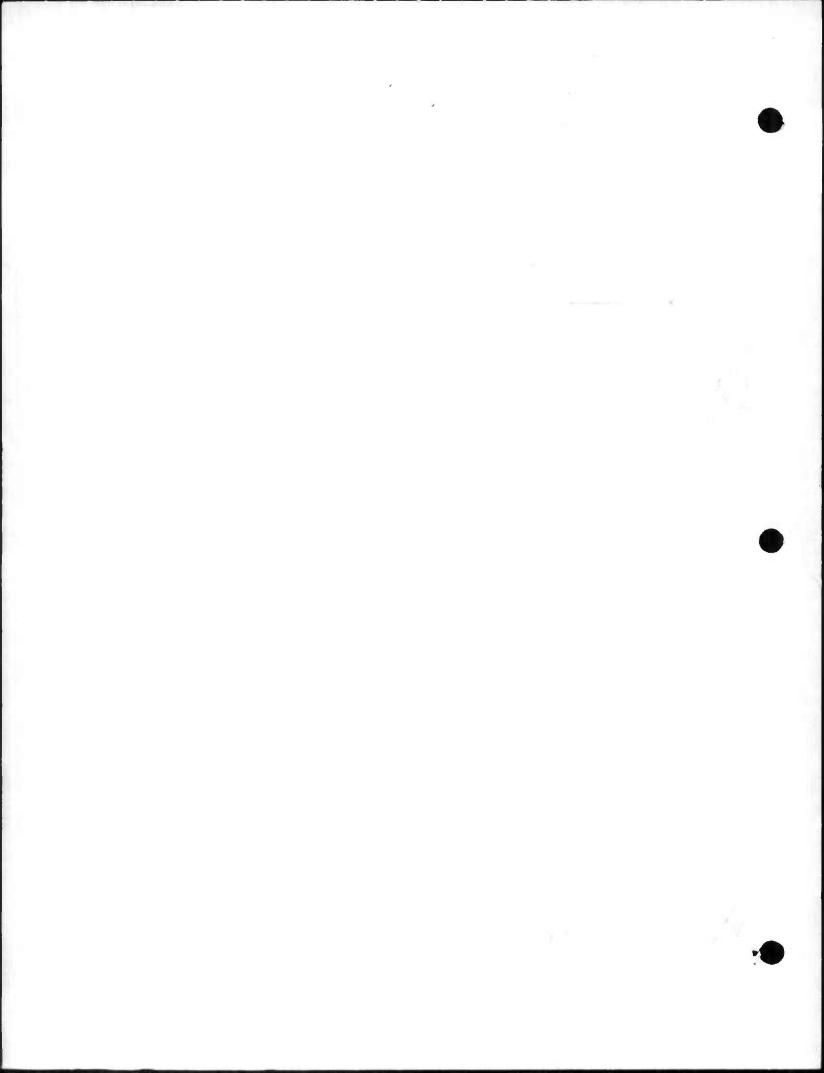
1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	- 1				1120.110.		
	-		1. DECEDENT'S NAME (First, Middle, Last) OS CAR MURRAY		2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH	
					JULY 6th 1995	1	
			4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. leet birthd) 7. Sex 7. Sex 9. AGE (In yrs. leet birthd) 7. Sex 9. AGE (In yrs. leet birthd)	MONTHS DAVID HOLDER	(Morsh, Day, Year) _ Cour	THPLACE (State or Foreign	
3	Dinous		9a. FACILITY NAME (If not institution, give street and number)		W. 17,1919	N.C.	
	200	œ		96, CITY, TOWN OR LOCATION OF DEAT	TH 9c. COUNTY OF	DEATH	
	, 2,	DIRECTOR	DT- HONES HOSPITAL	Da. 140.	~ (14	
		Ä	100. STATE 10b. COUNTY 10c.	CITY, TOWN OR LOCATION		10d. INSIDE CITY	
	permit, rages	<u>=</u>	Md NA	Balto		LIMITS?	
		₹	100. STREET AND NUMBER	101, ZIP CODE	10g. CITIZEN OF	WHAT COUNTRY?	
e i		5	141 Edgewood St.	51550	9 US	A	
020 physician	Durier-transit	FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 VES 2 NO	13. WAS DECENDENT OF HISPANIC If yes, specify Cuban, Mexican,		CE — American Indian, ck, White, etc.	
	3	ВУ	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES	1 TYES 2 NO Specify:		on RIAL	
215-0 attending	8	60	15. DECEDENT'S EDUCATION 16e. DECEDEN	1	PIACE		
2121 al or aft	200	ETE	(Specify only highest grade completed) (Give kind	I'S USUAL OCCUPATION of work done during most of working T use retired.)	16b. KIND OF BUSINESS/INDUSTRY		
ND 2	2		Elementary/Secondary (0-12) College (1-4 or 5+)	ift On a to	Longshore	CA de An	
AND the hospit	once.	COMPL	17. FATHER'S NAME (First, Middle, Last)	I ME MOTHER'S NAME	E (First, Middle, Maidell Surname)	MANIO	
4 4	8 %	ВС	JOHN T. MURRAY	DERTH	A Edwards		
MARYLAND retained by the hospit	notfled	0	. INFORMANT'S NAME (Type Print) 19b. MAIL	NG ADDRESS (Street and Number or Rural Roo			
be reta	, 21	2	Dertha Y. MURRAY 14	7 Edgewood 3	St. Bakbo Hd	21229	
W > 8	et be			TE OF DISPOSITION Name of	OATE 20c LOCATION - City or 1	Town, State	
	must		4 Dopation 5 Other (Specify)	Star Cenedery 1-	13-95 Baldo.	Hd	
LTIM ith. Page	examiner		EL SONATURE OF FUNERAL SERVICE LICENSEE	22 NAME AND ADDRESS OF FACIL	1 - 1 1 T	21215	
			Duris B. Scott	March tuper	ash Aur. Bak	1 11 1	
B after S	E 2		23. PA IT I. Enter the diseases, or complications that caused the death. D	o not antar the mode of dying, such		Approximate	
hours	D. O.		shock, a) heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final			Interval Between Onest and Death	
PZ U	the		disease or condition resulting in death)	MARY ARREST		(mms)(m	
60 with	i, crem event,		disease or condition	OF):			
587 Scurted		Z	META STATIL	PROSTATE	can LER	>17.	
X	nor to bunic traumatic	CATION	Sequentially list conditions, if any, leading to immediate	OF):			
BO cate b	d by	<u>2</u>	cause. Enter UNDERLYING CAUSE (Disease or Injury				
Certify O	oth	CERTIFI	that initiated events DUE TO (OR AS A CONSEQUENCE resulting in death) LAST	OF):			
eath D	Y, Or	8	d				
RDS at the de	d Menta Injury,		PART ii. Other aignificant conditions contributing to death but not resulting	g in the underlying cause given in Pa		b. WERE AUTOPSY FINDINGS	
0 5 8	£ 6	DICAL	thenge in mental state	M.	PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
	Hea W	ME				OF DEATH? 1 YES 2 NO	
law req	Dept. of n 23 sho		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH	YES INO I UNCERTAIN			
The law	State De	SICIAN:		EATH (Check only one)			
F VIT	he State or Item	Š	1 VES 2 ANO HOSPITAL:	OTHER: 4 Nursing Home 5 Residence 8	Other (Specify)		
HYSIC PIE	with th	РНҮ	(Month, Day, Year)	IME OF 28c. INJURY AT 2 INJURY WORK?	8d. DESCRIBE HOW INJURY OCCURED		
Z 5 5		B	1 ONetural 5 Pending 2 Accident Investigation	M 1 YES 2 NO			
ENDING B. After	D 60		3 Suicide 8 Could not be 28s. PLACE OF INJURY — At home, farm building, atc. (Specify)	n, street, factory, office 2	Ref. LOCATION (Street and Number or Rural City or Town, State)	Route Number,	
DIVISION OF VITA OR ATTENDING PHYSICIAN: The DIRECTOR: After this partificate in	m 28 I	COMPLETE	4 Homicide determined				
		립	29s. CERTIFIER (Check only 1) CERTIFYING PHYSICIAN: To the best of my knowledge, death occ	irred at the ilme, data and place, and due to	the cause(a) and manner as stated.		
HOSPITAL	MT:	S I	one) 2 MEDICAL EXAMINER: On the beels of examination and/or investig	ition, in my opinion, death occured at the tin	ne, date and place, and due to the cause((e) and manner se stated.	
THE HOSPITAL	be filed within 7	BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBI		D (Month, Day, Year)	
5 1	MP file	TO B	HOUSE OFFICER.	1 9-45	157 DULY	, 6th, 1995.	
		F	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (T)	pe, Print)			
				ARK CT, SILVET	- Spicing, M.	1 208-4.	
	7		31. DATE FILED (MONTH), Day, Year) 32. REGISTRAN'S BIGNATURE JUL 1 2 1995 Julia d'Audier Revell	, , , , , , , , , , , , , , , , , , ,			
			JUL 1 2 1995 Julia d'audeor Karlall			1	

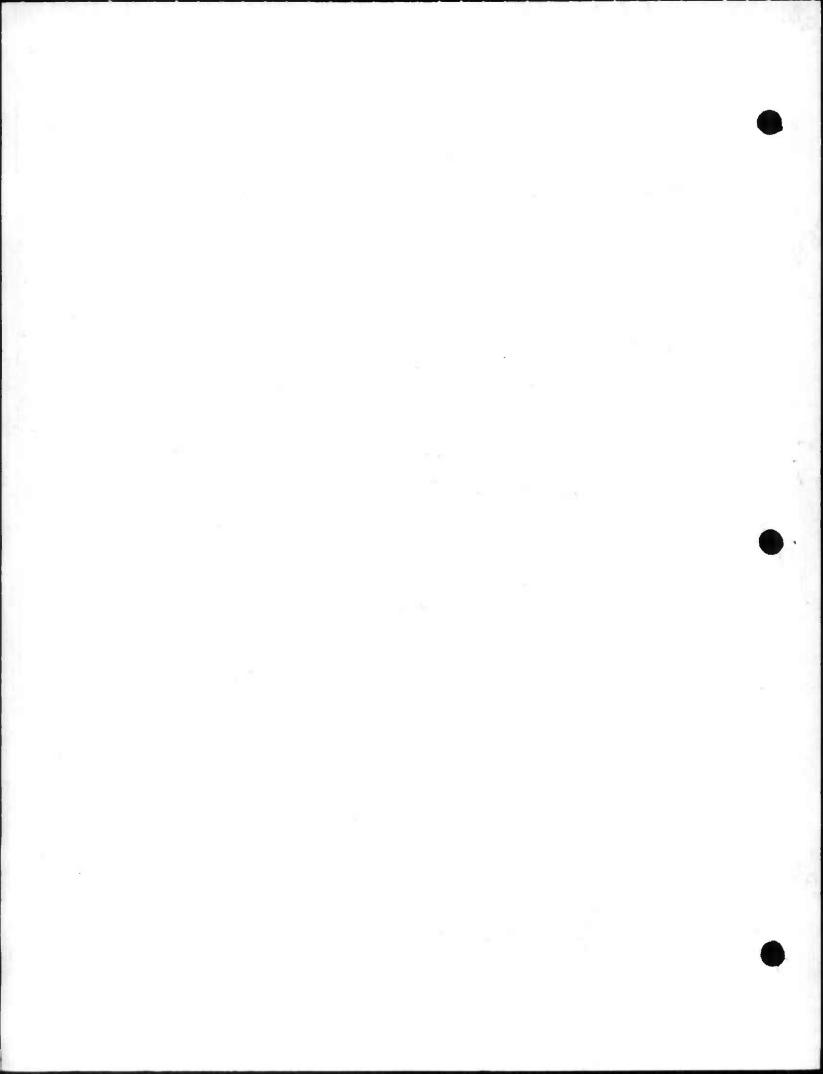
BALTIMORE, MARYLAND 21215-0020	main and a strenging physician.	and the second for use as the burial-transit permit. Pages 1	R	nowill Mine Lorica
BALTIMORE,	hours after death. Page 6 may be	ed in by the funeral director, page	or removal.	medical examiner must be
DIVISION OF VITAL RECORDS, P.O. BOX 68760	OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may by mysterm have all or attending physician.	UNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page	ithin 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be not in the medical examiner must be not in the medical examiner must be not in the medical examiner must be not in the medical examiner must be not in the medical examiner must be not in the medical examiner must be not in the medical examiner must be not in the medical examiner must be not in the medical examiner must be not in the medical examiner must be not in the medical examiner must be not in the medical examiner.

ENE											
NO. 3. TIME OF DEATH											
DAY 1995 4:00 PM											
8. BIRTHPLACE (State or Foreign Country)											
934 MO											
9c. COUNTY OF DEATH											
10d. INSIDE CITY											
1 VES 2 NO											
10g. CITIZEN OF WHAT COUNTRY? US A											
Yes or No— 14. RACE — American Indian, Black, White, atc. Specify: BLACK											
BUSINESS/INDUSTRY											
LUSTRY											
Iden Surname)											
MARTIN MCLEAN ROWN, State, Zip Code)											
no. 21244											
LOCATION — City or Town, Stata BALT MD.											
HOME											
ST BALT MD 21213											
papiratory arreat, Approximate interval Batween											
Onset and Death											
AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO											
S 2 NO COMPLETION OF CAUSE OF DEATH?											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN											
1 TES 2 NO											
1 Tes 2 No											
W INJURY OCCURED											
est and Number or Rural Route Number, late)											
W INJURY OCCURED set and Number or Rural Route Number, ate)											
est and Number or Rural Route Number, late)											



1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		4 DECEMBER HAME OF A			_	OLITIII	ICATE	_ 01	DEAT	<u>n</u>	REG			
		1. DECEDENT'S NAME (First,	Middle, Last)		3.6	OODE				1	NONTH	TH DAY	VEAR	. TIME OF DEATH
		WILBERT				OORE				i	JULY 2	,1995		3:00 A M
		4. SOCIAL SECURITY NUMB		5. SEX	1111	rs, lest birthday)	IF UNDER	1 YEAR	IF UNDER		Month, Day, Ye		8. BIRTHPL Country)	ACE (State or Foreign
-		239-22-42	57	1 2 M 2 🗆 F	76	YRS.	anom trus	DAYS	HOURS	MIN.	4-30-1	919	oounay)	N.C
3 should		9a. FACILITY NAME (If not ins					9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF					NTY OF DEA	тн	
	R C	4939 SINC.	LAIR	LN			1	BA	LT,				11/1	9
1, 2,	DIRECTOR	RESIDENCE OF DEC	EDENI											
Pages	8	10e. STATE	10b. COUNTY	Y /	2	10c. CI	TY, TOWN C						10	Od. INSIDE CITY LIMITS?
±.		MD		NI	7		BA	L7					1	VES 2 NO
permit.	AL	104. STREET AND NUMBER						10	1. ZIP CODE			10g. CITI	ZEN OF WH	AT COUNTRY?
. <u>15</u>	FUNERAL	1708 N. Broadway 21213 USA.												
020 physician. burial-transit	3	11. MARITAL STATUS	/	12. WAS DECEDER	NT EVER IN U.	S. ARMED	13.	WAS DEC	ENDENT OF	F HISPANIC	ORIGIN? (Speci			- American Indian,
Delays During		1 Never Married 2	Merried	FORCES?	1 YES 2	2 AND		If yes, sp	ecify Cuban	Mexican, I	Puerto Ricen, et	c.)	Black, Y	White, etc.
5-0020 inding physic as the burial	≧	3 Wildowed 4 Divor	ced	II 120, GIVE	THAT ON DATE	•		TES	2 PNO	Specify:		-	Specify:	BLACK
215-0 attending se as the	유	15, DECE	a. DECEDENT'S	USUAL O	CCUPATIO	ON		16b, KIND 0	F BUSINESS/INC					
E 8 2		(Specify only Elementary/Secondary (0-	highest grade	College (1-4 or 8		(Give kind of life. Do NOT u	work done (se retired.)	during mo	ost of working		S=0/2000 F			
	7	(12)		MAChi	VE E	DOFE	ATO	0	LONG	SHORE	EMAR	7		
AND the hospit detached once.	COMPL	17. FATHER'S NAME (First, Mic	idle (ast)	NIA		711-1111		7-1			(First, Middle, M			
YLA by the be det		LARENCE	. ,	COLE										
IAR National Distriction of the should of th	BE	19e. UNFORMANT'S NAME (Ty		DUZZ		T			1	ARY		or Town, State, Zip	0N9	
MARYLAND retained by the hospit should be detached notified at once.	임			- 11		196. MAILING	ADDRESS	(Street a	and Number (or Rural Rou	te Number, City o	or Town, State, Zip	Code)	_
2 8 9		VELVIA J.		PE		1108	N	BRO	Adu	JAY	BA CT	m D	2/2/	3
BALTIMORE, after death. Page 6 may be by the funeral director, page moval. cal examiner must be		20e. METHOD OF DISPOSITION 1 2 Burlet 2. Cremetter		oval from State	20b.PL	ACE AND DATE	OF DISPOS	ITION (N	ame of	/	DATE 20	c. LOCATION	City or Town	, State
MO See Se See Se See Se See Se See Se See Se S		4 Donation 6 Other	,		- Vo:	SHELL	m	EM.	PAI	RK	7/1/95	BAL+	MD	
SALTIN r death. Pag e funeral die al. examiner		21. SIGNATURE OF FUNERAL	SERVICE LIC	ENSEE			22.	NAME A	ND ADDRES	S OF FACIL	ITY /			
AL death death tune tune tune		1 nh	in	2	7/		00	113	TUN	VERA	-L MU	m E		
the the		22 Darrie L Enter the di			u	a victoria de	11	29	N: C	-A 120	LINE S	ST NAL	+ m	D 21213
S C D		23. PART I. Enter the die ehock, or he	ert fellure.	List only one car	use on eech	line.						reepiratory err	est,	Approximate Interval Between
y filled ition, or the m		IMMEDIATE CAUSE (Fine	ol .	MOV	ankh	ic s	Jas	Ki	0	Can	(OH)			Onset and Death
		disease or condition resulting in death)	>	111 01		-)				-0			2-3 Jus.
	,	DUE TO (OR AS A CONSEQUENCE OF):												
	z			b										
X 8 5 9 E	ERTIFICATION	Sequentially list conditione, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):												
BO ante br hysicie prior	8	CAUSE (Disease or John		c										
O. In the serific:	프	CAUSE (Disease or Injury that Initiated evente DUE TO (OR AS A CONSEQUENCE OF):												
		resulting in deeth) LAST	D:	d										
the death the attend Mental H injury, or	O	DARW II On a standing												
T + 55 -	EDICAL	PART II. Other eignificar	condition	Contributing to	deeth but r	not resulting	in the un	deriyin	g couse gl	iven in Pa	rt i. 24a. Wi	S AN AUTOPSY		ERE AUTOPSY FINDINGS MILABLE PRIOR TO
O # 8 # 8	8	1 Preumon	(d)	2/ 1100	ma	(3) 51	enore	_ N	Jum	W 4/1	1 TY	ES 2 DAO	C	OMPLETION OF CAUSE F DEATH?
puires puires r sign Healt	ME													YES 2 NO
AL RE he law request best of the second of t		DID TOBACCO US	E CONTI	RIBUTE TO CA	USE OF D	DEATH YI	ES 🗆 N	NO [UNCE	ERTAIN	'nl		1.0	
ATTENDING PHYSICIAN: The law ECTOR: After this certificate has b s after death with the State Dept.	SICIAN	25. WAS CASE REFERRED TO				PLACE OF DEA		_	2.101	1/1 T	-			
SICIAN: The certificate h the State (1, or Item	Sic	EXAMINER?		HOSPITAL:	FR/Outpatie	or 3 □ DOA	OTHER	t:	. 15/		Other (Specify			
Sicia certif	PHY	27. MANNER OF DEATH		25e. DATE OF		26b. TIM		28c. INJ				OW INJURY OCC	CUBEO	
NG PHYSIC frer this ce sath with tr		1 Natural 5 P	ending	(Month, D		IN.	JURY M	WO	RK?		PO. DESCRIBE N	OW INJURY OCC	UNED	
DINICAL DINICAL DINICAL DIRECTOR: After hours after death item 28 is man	B		rvestigation	280 BLACE C	OF IN HUMA	At home, farm,			YES 2 [
TTEND TTOR: /			ould not be etermined	building,	atc. (Specify)	AL THORNE, TEITH,	street, met	огу, отне	•	20	City or Town,	treet and Number Stete)	or Rural Rout	te Number,
DR ATTEN DIRECTOR: hours after Item 28 Is	П													
AL DIRECTOR AL DIRECTOR HOURS	COMPLET	(Check only	FYING PHYSI	CIAN: To the best of	my knowledg	e, death occurr	ed at the ti	me, date	end place,	end due to	the cause(e) en	d manner as state	ed.	
HOSPITAL FUNERAL WITH 72 TANT: If	8	one) 2 MEOIC	AL EXAMINE	FI: On the beele of e	xamination an	d/or investigation	on, in my o	pinion, d	eath occurs	d at the firm	a, date end plac	e, end due to the	e ceuse(s) si	nd manner as stated.
HO WITH		296. SIGNATURE AND TITLE								NSE NUMBE				onth, Day, Year)
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: II	BE	IV.	alvie	1,2000	- M	D			D-	-38	754	· > 7	161	95
5 5 8 W	유			COMPLETED CALL	SE OF DEATH	(ITEM 27) (Tex-	(Dylpst)		1		-	1 /	10/	,_
		MALIKA WA	SEEN	1 M.D.	100	N. 15	ROI	4Di	DAY,	, B,	ALTIM	ORE, 1	MD:	21231.
0	- 1	31. DATE FILED (Month, Day, Y	_		•						·			,
- 5			95 8	the diward	or Parta	Ц								
/ /		JULIAIS	00											



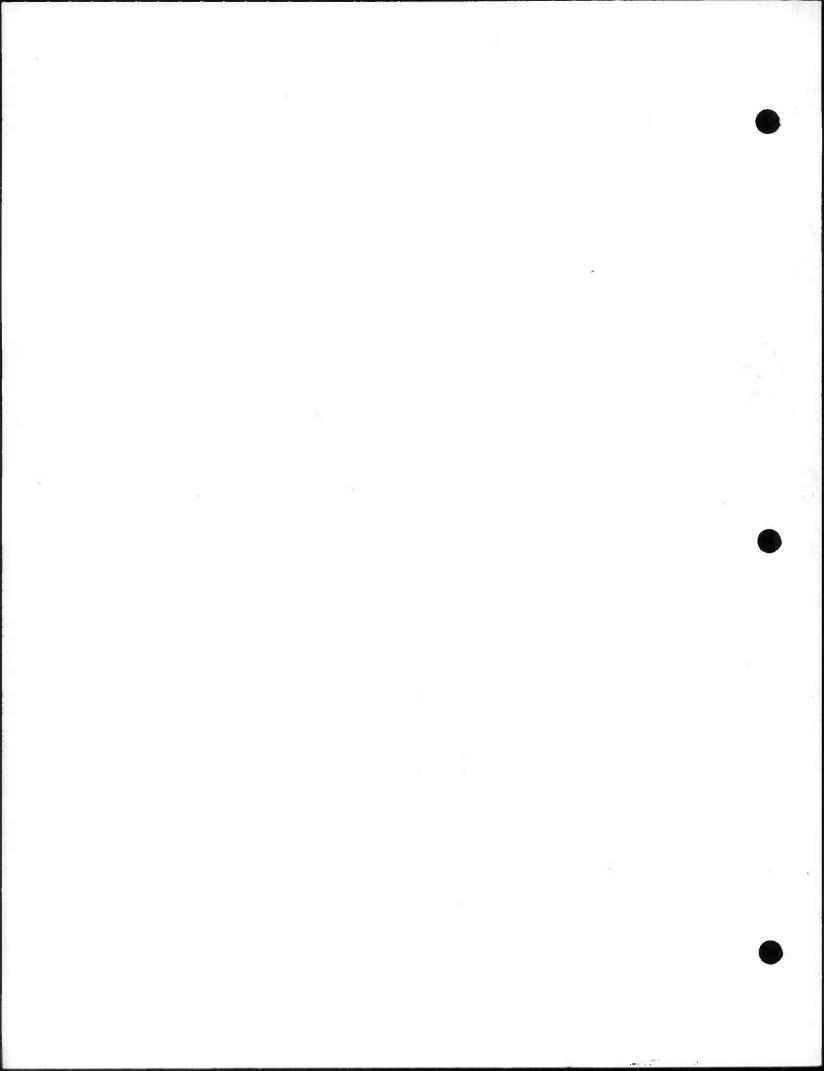
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hyghere prior to build, cernation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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31. DATE FILEO (Month, Day, Year)

32 REGISTRAR'S GRATURE

	FOR	STATE OF I	AADVIAND /	DEDAL	TAGEN	T 05 II	CALTU	AND	14° 11'T	N IIVolen			.0330
	1 - STATE REGISTRAR	SIMIE OF I	/ MARYLAND CI	DEPAR ERTIF					MENIA	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) May	y O'Conn							S-OF DEATH	7.1	992	3. TIME OF SEATH,	
	4. SOCIAL SECURITY NUMBER 016-01-7175	5. SEX 1 M 2 AF	The state of the s		24 HRS. MIN.	7. DATE OF BUILTH JULY 9, 1898		//-/- 98	8. BIRTHPLACE (State or Foreign Massachusetts				
OR	9a. FACILITY NAME (If not institution, give a Dulaney-Towson He						EATH			UNTY OF D			
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	,		T 100 CIT	V TOWN	OR LOCAT	1011						
띩	Maryland Balti			10C. G1	i, iown	OH LOCAI	Phoe	mise					10d. INSIDE CITY LIMITS?
1	100. STREET AND NUMBER	IIOTE		<u> </u>		101	ZIP CODE				10- 017	PIZEN OF I	1 TYES ZONO
FUNERAL	3011 Jackson Ridg	e Court				100.		1131				USA	WHAT COUNTRY?
🛓	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	MED	13	WAS DEC				IN? (Specify Yea			E — American Indien,
BY	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1	YES 2X1	40	10.	It yee, spe	2 XNO	n, Maxice Specify	n, Puerto y:	Ricen, etc.)	or No —	Blac	k, White, etc.
	15. DECEDENT'S EDU (Specify only highest grade		16a. DE	CEDENT'S	USUAL O	CCUPATIO	N		16	b. KIND OF BUS	SINESS/IN		
COMPLETED	Elementary/Secondary (0-12) 8th	College (1-4 or 5 a		the kind of Do NOT us escl		during mos	st or workin	g	(Clothin	g Re	tail	
BE CON	17. FATHER'S NAME (First, Middle, Last) "Unknown"	0'Connor					16. MOTH			Middle, Malden	Surneme)		
10	190. INFORMANT'S NAME (Type/Print) Wayne Lawrence Ha	rdesty	30	b. MAILING)11 J	acks	s (Street e	idge	or Rural F	Phoute Nur	onber, City or Town	MD 2	1131	
	20e. METHOD OF PISPOSITION 1 General 2 Greenation 3 Greenoval from State 4 Greenation 6 Green Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Mine of Particle Stry), Inc. 07/10/95 Baltimore, MD												
	21. SIGNATURE OF FUNERAL SERVICE LIC	nald	_ [29	9 Fr	eder	ick	Rd.	of Mar Baltim	ore,	MD	nc. 21228		
-	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, Shock, or heert failure. List only one cause on each line.											Interval Between	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	c	DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
岗		d		····							-		
4	PART II. Other significent condition	a contributing to	deeth but not r	eeuiting	in the ur	nderlying	cauee g	iven in	Part i.	24a. WAS AN		24b	. WERE AUTOPSY FINDINGS
MEDICAL								í.		PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
ᇦ							/						OF DEATH? 1 YES 2 NO
	DID TOBACCO USE CONTI	RIBUTE TO CA	USE OF DEA	TH YE	S 🔲	NO [UNC	ERTAIN	N 🗆				
SIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLAC	E OF OEA									
SIC	1 YES 2 LINO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHE		5 🗆 Re	eldenca	6 🗆 Oth	er (Specify)			
BY PHYSICIAN:	27. MANNER QE DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF (Month, Da		26b. TIM		26c. INJL WOI	JRY AT		28d. DE\$CRIBE HOW INJURY OCCURED				
	3 Suicide 6 Could not be determined	28e. PLACE O building,	F INJURY — At ho etc. (Specify)	me, term, :						CATION (Street e y or Town, Stete)	nd Numbe	r or Rural I	Route Number,
COMPLETE	29e. CERTIFIER 1 CSRTIFYING PHYSION 2 MEDICAL EXAMINE												i) and manner ea stated.
BE C	2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(a) and manner es stated. 295. BIGNATURE AND TITLE OF CENTIFIER 296. DATE SIGNED (Month, Day, Year) 7-9-95												

		1 - FOR STATE OF MARYLAND / CE	DEPARTMENT OF HI		MENTAL HYGIEN REG. NO.					
	1	1. DECEDENT'S NAME (First, Middle, Lest) Betty J. McCord			2. DATE OF DEATH		3. TIME OF DEATH			
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last		IF UNDER 24 HRS.	July 10	8. E	BIRTHPLACE (State or Foreign			
pin		215-32-9065 ¹□м²⊠ғ 59	YRS.		(Month, Day, Year) January 21	,1936				
2, 3 should	СТОВ	3518 Royston Ave.	Baltimo	re, Mar		9c. COUNTY	OF DEATH			
4-2	I III	10e. STATE 10b. COUNTY	10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY			
permit, Pages	L DIR	Maryland N/A	Baltimore,	Marylar	nd	IAA CITITEN	LIMITS? 1 YES 2 NO OF WHAT COUNTRY?			
- TS	FUNERAL	3518 Royston Ave.	1000	21214	21206		S.A.			
215-0020 attending physician. use as the burial-transit	BY	11. MARITAL STATUS 1 \(\sum \) Never Married 2 \(\sum \) Merried 3 \(\sum \) Wildowed 4 \(\sum \) Divorced 12. WAS DECEDENT EVER IN U.S. ARI FORCES? 1 \(\sum \) YES 2 \(\sum \) N IF YES, GIVE WAR OR DATES	MED 13. WAS DECE	NDENT OF HISPAN	IC ORIGIN? (Specify Yee n, Puerto Rican, etc.)	or No- 14.	RACE — American Indien, Black, White, etc. Specify: White			
r attend	TED	(Specify only highest grade completed) (Gir	CEDENT'S USUAL OCCUPATION we kind of work done during most	N t of working	16b. KIND OF BUS	SINESS/INDUST				
6 1 1	COMPLE	Elementary/Secondary (0-12) College (1-4 or 5+)	tomer Service	Pop	Banki	na				
BOR S	COM	17. FATHER'S NAME (First, Middle, Last)			ME (First, Middle, Maiden					
	BE	Charles McCord 19a. INFORMANT'S NAME (Type/Print) 19b.	. MAILING ADDRESS (Street en		Weitzel					
2 8 8 8	押	Maryanna Hunger	Same as		loute Number, City or Town	n, State, Zip Cod	le)			
\$ 6 d		1 LX Buriel 2 □ Cremation 3 □ Removal from State cemeterv.crem	IND DATE OF DISPOSITION (Name		DATE 20c. LO	CATION - City	or Town, State			
Page 6		4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIGHNSEE	ns of Faith	7/14/95 ADDRESS OF FAC	Ва	ltimor	e , Maryland			
BALTIMORE, after death. Page 6 may be by the funeral director, page moval.	Ш	Monaly C Shope he	Balti	more . M	ick Funeral	21214				
within 24 hours whetely filled in teremation, or re-		23. PART I. Enter the diseases, pr complications that caused the december, pr heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSECTION OF TO		e of dying, suct	n as cerdiec or respi	ratory arrest,	Approximate Interval Between Onset and Death			
P.O. BOX 68: th certificate be execute anding physician and co Hygiene prior to buria or other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. MGTASTATIC AMBRO CARCUMMA OF CONSEQUENCE OF): C. AMBRO CARCUMMA OF ESOPHARUS DUE TO (OR AS A CONSEQUENCE OF): d.								
RDS at the day the by the and Mer willing	JAL	PART II. Other significent conditions contributing to death but not re	sulting in the underlying	ceuee given in l	Part I. 24s. WAS AN PERFOR	IMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO?			
TAL REC The law requires te has been signified begin of Healt em 23 shows		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEAT		UNCERTAIN	10					
F VITA SICIAN: The certificate h the State C	SICIAN:	25. WAS CASE REFERRED TO MEDICAL CAMINER? 1 YES 2 HOSPITAL: 1 Input lent 2 ER/Outpatient 3	OTHER: DOA 4 Nursing Home							
NG PHYSICIAN: tter this certifica eath with the Su marked, or it	PHY	27. MANNER OF DEATH 1 Natural 5 Pending 26. DATE OF INJURY (Month, Day, Year)	26b. TIME OF 28c. INJUI INJURY WOR	RY AT	28d. DESCRIBE HOW IP	NJURY OCCURE	iD			
ISIC TTENDI TTOR: A after d	TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At hon building, etc. (Specify)		.5 2 0 110	281. LOCATION (Street e City or Town, State)	ind Number or R	ural Route Number,			
DIV L ORREC L DIREC L DIREC L DIREC L DIREC	COMPLETED	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dea	ith occurred at the time, date a	nd place, and due	to the cause(s) and man	ner es stated.				
OSPITA UNERA Ithin 72	COM	one) 2 MEDICAL EXAMINER: On the basic of examination end/or in					use(s) and menner as stated.			
TO THE HOSPITAL C TO THE FUNERAL D De filed within 72 ho IMPORTANT: If IN	BE	29b. SIGNATURE AND TITLE OF CERTIFIER	5	D 369			TILS			
	10		(50 N BROW	Anny	BALTIN		mo 21231			
1/3		31. DATE FILED (Month, Day 1997) 32. REGISTRAL'S SIGNATURE June Day Control	rdall	· · · · · · · · · · · · · · · · · · ·						



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or flem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR		CERTIFI	CATE OF DE	ATH	REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Las	ø			1	2. DATE OF DEATH		3. TIME OF DEATH				
	John T	ee	Marr	Sr.		July 8	1995					
	4. SOCIAL SECURITY NUMBER		8. AGE (In yrs. last birthday)			7. DATE OF BIRTH		6:00 A. M				
	217-20-4584	1 XM 2 - F		MONTHS DAYS HOU	RB MIN.	(Month, Day, Year) larch 14, 1	1923 Ma	THPLACE (State or Foreign ntry) Tyland				
R.	9a. FACILITY NAME (If not institution, given 100 Mellor	e street and number) Avenue		96. CITY, TOWN DR LOC Cato	ATION OF DEAT	9c. COUNTY OF Balti	DEATH					
DIRECTOR	RESIDENCE OF DECEDENT											
ĬŽ	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY											
1 1	Maryland Ba	ltimore			nsville	<u> </u>	LIMITS? 1 ☐ YES 2 ☑ ND					
FUNERAL	4.00	Avenue		101. ZIP C	21228			WHAT COUNTRY?				
5	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. ARMED	13. WAS DECENDED	T DF HISPANIC	ORIGIN? (Specify Yes	or No- 14. RA	CE American Indian,				
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WA		If yes, specify C		Puerto Rican, etc.)	1	ok, white, etc.				
	15. DECEDENT'S Et (Specify only highest gra	DUCATION	16e. DECEDENT'S U	ISUAL OCCUPATION		16b. KIND OF BUS	SINESS/INDUSTRY					
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	ork done during most of w retired.)	onung							
COMPLETED	11			Owner		Reta		es				
	17. FATHER'S NAME (First, Middle, Last)					(First, Middle, Melden	Surname)					
B	Grover C. Marr 19a. INFORMANT'S NAME (Type/Print)		405 44411 1910	C. ADDRESS (Street and Num	lara P.							
임	Shirlev Marr (Spouse)		ellor Aveni				3 21220				
i	29a. METHOD OF DISPOSITION	-	20b. PLACE AND DATE OF	DISPOSITION-Warrent	40 40	ON TE 20c 100	CATION - City or	Town State				
	4 Donation 5 Other (Specify)	1 Mountain 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Granite Presby Church Cemetery Granite, Maryland										
Ш	21. SIGNATURE OF PENERAL SERVICE	10	21.		Russe	ll C Witz						
Н	22 DADT I Estar the diseases		ree .	1630 Edmo	ondson	Avenue Ca	tonsvil	le,Maryland				
	23. PART I. Enter the diseases, or ahock, or haert failure	. List only one cause	e on sech ilna.	ot enter the mode of	dying, such a	a cardlec or reapl	ratory arreat,	Approximate interval Between Onset and Death				
	disease or condition Acute Muncardial Inferction											
	resulting in death) a. ACUTE MYOCARCIVAL INFARCTION DUE TO (DR AS A CONSEQUENCE OF): Coronary Artery Disease											
NO												
CAT	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	С										
CERTIFICATION	that initieted events resulting in desth) LAST	DUE TO (D	R AS A CONSEQUENCE OF):	:								
빙		0										
DICAL	Chronic Re	one contributing to d	eath but not resulting in	the underlying caus	e given in Pa	rt i. 24a. WAS AN . PERFOR		b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
ă	Remote Le	Ca Ilai	· rure			_ 1 _ YES 2	X NO	COMPLETION OF CAUSE OF DEATH?				
X						_		1 TYES 2 ND				
AN	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CAU	26. PLACE OF DEATH		NCERTAIN							
띯	EXAMINER? 1 YES 2 M ND	HOSPITAL:		OTHER:		19						
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE DF IN	JURY 28b. TIME			J Other (Specify) Bd. DESCRIBE HOW IN	JURY OCCURED					
ВУ Р	1 Natural 5 Pending 2 Accident Investigation			M 1 TES								
TED	3 Suicide 8 Could not be determined	28e. PLACE DF I building, etc	INJURY — At home, ferm, atr c. (Specify)	eet, fectory, affice	28	Bf. LOCATION (Street e. City or Town, State)	nd Number or Rural	Route Number,				
PLE	290. CERTIFIER (Check only	SICIAN: To the beat of m	y knowledge, death occurred	at the time, date end pl	ice, end due to t	the cause(e) end man	ner as stated.					
COMPLETE	299. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as atsted. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) and menner as stated.											
TO BE	SIGNATURE AND TITLE OF CENTIFI	eor My	Physic	18	1955 &	3	►7-1	D (Month, Day, Year) 1 - 95				
				medica	John	Suite &	-05					
	JUL 1 2 1995	36 REGISTRAR	SACH TURE									

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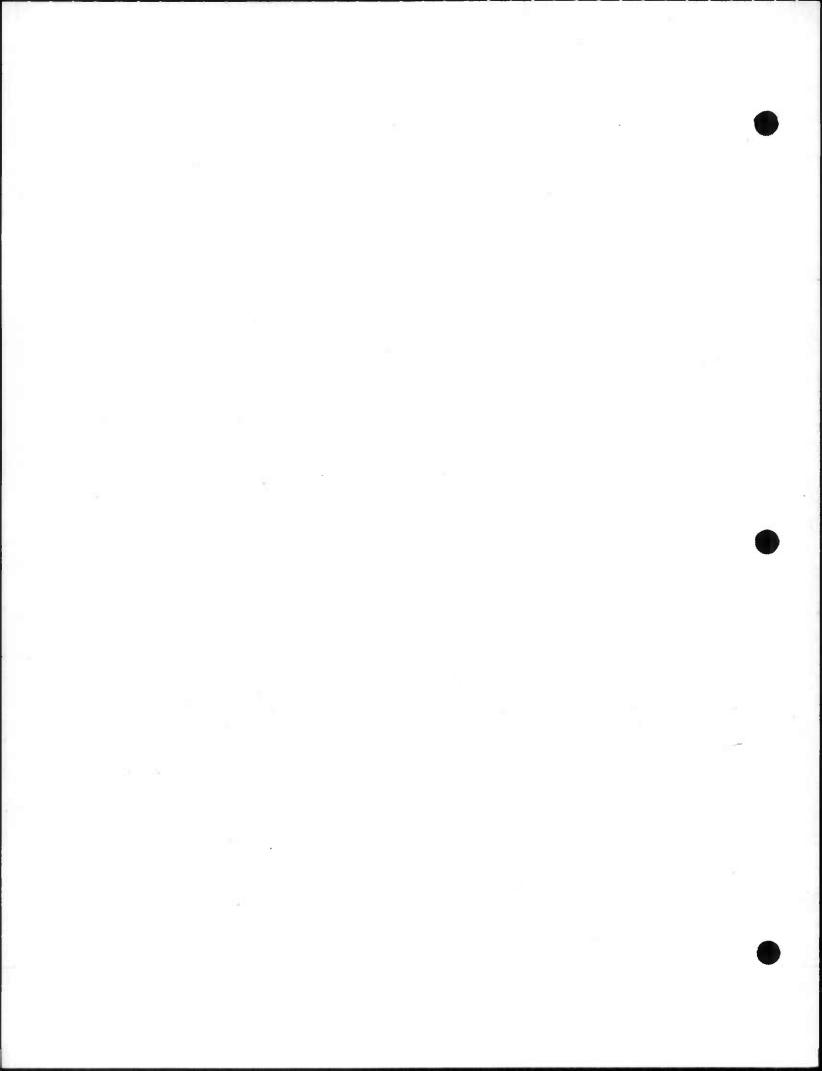
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the flow in ster death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

UNK 95-165

	REGISTRAR		CERTI	FICATE O	DEATH	REG. N	0.				
	1. OECEDENT'S NAME (First, Middle, Last)				2. DATE OF OEATH			3. TIME OF OEATH			
	JOSEPH PAUL			NIRODA			MONTH DAY YEAR				
	4. SOCIAL SECURITY NUMBER	5. SEX 6. /	AGE (In yrs. last birthday) IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH			5 • 21 A ^M PLACE (State or Foreign		
	216-96-4328	1 🔀 M 2 🗌 F	26 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) Aug. 27,		Country)		
	Se. FACILITY NAME (If not institution, give :	street and number)		9b. CITY, TOWN	OR LOCATION OF DE		9c. COUN				
OR	6000 BLK MORA	VIA PARK	DRIVE	BALTIMORE CITY N/A							
DIRECTOR	RESIDENCE OF DECEDENT										
뿐	10e. STATE 10b. COUNT		100	ITY, TOWN OR LOC					10d. INSIDE CITY LIMITS?		
		N/A	E	altimore					1 T YES 2 NO		
FUNERAL	10e. STREET AND NUMBER			1	of. ZIP CODE		10g. CITIZ	EN OF W	NAT COUNTRY?		
ij	2521 Hamilton Ave				21214		U.S	S.A.			
2	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EV FORCES? 1	ER IN U.S. ARMED	13. WAS DE	CENDENT OF HISPAN	NIC ORIGIN? (Specify Y	ea or No-	14. RACE Black	- American Indian, White, etc.		
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR			S 2 XNO Specifi			Whi			
9	16. OECEDENT'S EDU	1	1						Le .		
	(Specify only highest grade	completed)	(Give kind o	S USUAL OCCUPAT	TION nost of working	16b. KINO OF B	USINESS/INDU	STRY			
ויי	Elementary/Secondary (0-12)	L Year	Painte			Paint	Contra	ato	r		
COMPLET	17. FATHER'S NAME (First, Middle, Last)	tear	Pallice	Т.	1			ic w.	L		
ၓ၂	Joseph Paul Niro	72 CF				ME (First, Middle, Maide					
96	19a. INFORMANT'S NAME (Type/Print)	ac, or.				ouise Less					
임	Mary Louise Less	ner Rolstor				Route Number, City or To Baltimore			3 2121 <i>4</i>		
	20s. METHOD OF DISPOSITION	101501					-				
	12 Burial 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	ioval from State	20b. PLACE AND DAT COMMETTER COMMETT	other place)	Compt 7/13/9		OCATION — C	•			
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	Gardens C				тшюге	, IVE	aryland		
	John C. Miller, Inc.										
	Ballen	Mr. Mee	yeary	6415	Belair Ro	oad, Balti			yland 21206		
	23. PART I. Enter the diseases, or shock, or heert failure.	List only one cause	used the death. Do	not enter the m	ode of dying, suc	h ea cardiec or ree	piratory arre	at,	Approximata		
	IMMEDIATE CAUSE (Final	Limit office cause (on econ inte.						Interval Between Onset and Death		
- 1	disease or condition resulting in death)	a. GULSI	10T 112h	12NO 0	E WECK						
		DUE TO (OR	AS A CONSEQUENCE	OF):							
z I	Sequentially list conditions b										
Ĕl	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										
2	Cause. Enter UNDERLYING CAUSE (Disease or Injury										
CERTIFICATION	that initiated events resulting in death) LAST										
		d									
	PART II. Other algnificant condition	ne contributing to dea	th but not recuiting	In the underlyi	ng ceuse given in	Pert I. 24s. WAS A		24b.	WERE AUTOPSY FINDINGS		
DICAL						PERFO	RMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE		
MED						TES	2 NO	1	OF DEATH?		
2	DID TOBACCO USE CONT	RIEUTE TO CAUS	F OF DEATH	FS [] NO [UNCERTAIN				1 YES 2 NO		
₹	25. WAS CASE REFERRED TO MEDICAL			ATH (Check only one		10]					
PHYSICIAN:	EXAMINER?	HOSPITAL: 1 - Inpetient 2 - ER/	Outpatient 3 DOA	OTHER:	me 5 🗆 Residence	6X Xother (Specify)	SCENE				
Ė	27. MANNER OF DEATH	28a. DATE OF INJU	28b. TI	ME OF 28c. IN	IJURY AT	28d. DESCRIBE HOW		IRED			
	1 Natural 5 Pending	(Month, Day, Ye	0	JURY W	YES 2 NO		SCT		ot		
B	2 Accident Investigation 3 Sylcide 6 Could not be	28a. PLACE OF IN.	JURY — At home, farm		Ica						
	3 Suicide 4 Homicide 6 Could not be detarmined 28a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) City or Town, State) 28b. LOCATION (Street and Number or Rural Roul City or Town, State)							D. OLON - WW			
۳ ا	29a. CERTIFIER 1 CERTIFYING BUYE							K 12	Talled to be		
<u> </u>		ICIAN: To the best of my i									
	A	R: On the basis of examin	endry endror investigat	tori, in my opinion,			nd due to Iha	ceuse(a)	and manner as stated.		
8	296. SIGNATURE AND TITLE-OF CERTIFIE			29c. LICENSE NUM		29d. DATE	SIGNED (Month, Day, Year)			
BE COMPLETED	11/00-1	W 11.	Mount mellelle					O.C.M.E JULY 10.199			
BE	Mount me	Kelle			0.C.M.	E	JI	ULY			
TO BE CO	MANE AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF	F DEATH (ITEM 27) (5/1	e, Print)					10,1995		
BE	MANE AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF	M 111 F	e, Print) Penn Sti		altimore			10,1995		

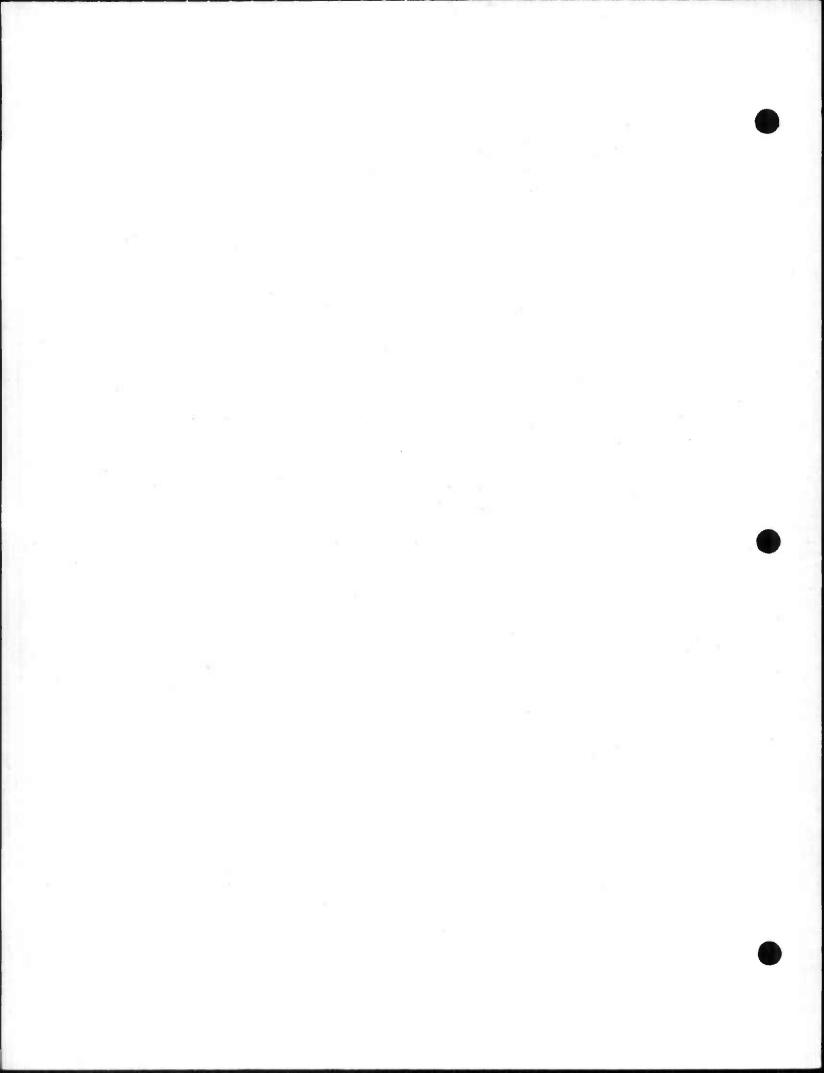


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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH MONTH 3. TIME OF DEATH Allen E. Prentice July 1995 10:00A M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) Jan 13, IF UNDER 1 YEAR | IF LINDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 370-10-8180 1 N M 2 □ F 81 DAYS HOURS VRS Michigan 1914 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 95 CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR 6336 Cedar Lane Howard Columbia RESIDENCE OF DECEDENT 10a STATE IOC. CITY, TOWN OR LOCATION 10h COUNTY 10d. INSIDE CITY Howard Columbia 1 YES 2 NO permit. FUNERAL 10e, STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6336 Cedar Lane and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit to burial, cremation, or removal. #104 21044 USA Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ∑ YES 2 □ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White BY 3 🔀 Widowed 4 🗌 Divorced Unknown COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Che kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade complete) (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Lt. Colonel U.S. Army 2 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Mary Cooley Frank Prentice notified at BE 19a, INFORMANT'S NAME (Type/Print) 19b, MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Jim Highsaw (Son-in-Law) 104 Glenrae Drive, Catonsville, MD 21228 9 20a, METHOD OF DISPOSITION
1 № Burlel 2 □ Cremation 3 ☒ Removal from State July 1995 20b. PLACEAND DATE OF DISPOSITION (Name of DATE 28c. LOCATION — City or Town, State must Riverside Cemetery 4 Donation 5 Other (Specify) Hastings, Michigan examiner 21. SIONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACUTY Leroy & Russell Witzke Funeral Home hours after death. Jucacuca 5555 Twin Knolls Rd. Columbia, MD 21045 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory errest, Approximate shock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death the disease or condition_ -Schemic Heart Disease 2m resulting in death) traumatic event, executed with DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): been signed by the attending physician a rt. of Health and Mental Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING certificate be other t CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 the death PART II. Other significent conditions contributing to death but not reaulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? that any 1 TYES NO OF DEATH? requires Shows 1 ☐ YES 2 ☐ NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\overline{\text{N}}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: has be 3W 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) The the State ltem. HOSPITAL: OTHER PHYSICIAN: 1 | YES 2 10 1 | Inpatient 2 | ER/Outpatient 3 | DOA Home 5 Rasidenca 8 □ Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT this c marked, 28b. TIME OF 26d. DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident M 1 YES 2 NO After t BY Investigation OR ATTENDING 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be DIRECTOR: / 4 Homicide 28 Hem 29a. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE BE filed within 72 he IMPORTANT: If It (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE William Tuly 5 PLETED CAUSE OF DEATH (ITEM 27) (Type, Print) -10 Wes 1

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BALTIMORE, MARYLANI	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	e death	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the for be filed within 72 hours after death with the State Dept. of Health and Memal Hyglene prior to burial, cremation, or removal.	luny.
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	PITAL	ERAL in 72	= 2
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	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTME CERTIFICATION	NT OF HEALTH AND TE OF DEATH	MENTAL HYGIE					
	1. DECEDENT'S NAME (First, Middle, Last) LENRY A. SOCIAL SECURITY NUMBER	EDMOND S. SEX. L. AGE (II	n yrs. Iast birthday) IF UN	DER 1 YEAR IF UNDER 24 HRS.	06 9	6 9	3 107 -			
	9. FACILITY NAME (If not institution, give str	112M2 0 F 81	7. DATE OF BIRTH (Month, Day, Year) O 1 - 8 -	(Month, Day, Year) 01-18-14 Country) S.C.						
STOR	EASTPOINT NURS	ING CENTER		BALTIMORE		N/				
DIRECTOR	100. STATE 10b. COUNTY MD	N/A		OR LOCATION CITY	7	2	10d. INSIDE CITY LIMITS? 1XXYES 2 NO			
FUNERAL	1425 N. DECKE	R AVE		101. ZIP CODE 21213	3	U.S	of what country?			
BY	11, MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 X NO	3. WAS DECENDENT OF NISP. If yee, specify Cuben, Mexic 1 YES 2 NO Specific	cen, Puerto Rican, atc.)	se or No — 14	I. RACE — American Indian, Black, White, etc. Specify: BLACK			
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementery/Secondery (0-12)	ATION ompleted) College (1-4 or 5+) N/A	16e. DECEDENT'S USUAL (Give kind of work do life. Do NOT use retired	e during most of working !.)	166. KIND OF B					
BE COM	17. FATHER'S NAME (First, Middle, Lest) HENRY H. REDM		LABOR		AME (First, Middle, Maide HO	n Surname)	ER			
TO E	198. INFORMANT'S NAME (Type/Print) LARRY REDMOND			SS (Street end Number or Rura IAMROCK AVE			MD. 21206			
	20e. METHOD OF DISPOSITION 1 Burlel 20 Cremetion 3 Removal from State 4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREENMOUNT CEME 6/28 BALTIMORE, MD.									
	21. SIGNATURE OF FUNERAL SERVICE LICENSIE 22. NAME AND ADDRESS OF FACILITY BETTS FUNERAL HOME 1129 N. CAROLINE ST. BALTO, MD21213									
	23. PART K Enter the diseases, of compilications that ceused the deeth. Do not enter the mode of dying, such as cardiec or reapiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) e. CARDIO PULMONARY ARREST									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): CARUMOMA OF COLOM WOLTH META STASIS DUE TO (OR AS A CONSEQUENCE OF): CARUMOMA OF COLOM WOLTH META STASIS DUE TO (OR AS A CONSEQUENCE OF): CARUMOMA OF COLOM WOLTH META STASIS DUE TO (OR AS A CONSEQUENCE OF): CARUMOMA OF COLOM WOLTH META STASIS DUE TO (OR AS A CONSEQUENCE OF): CARUMOMA OF COLOM WOLTH META STASIS DUE TO (OR AS A CONSEQUENCE OF): CARUMOMA OF COLOM WOLTH META STASIS DUE TO (OR AS A CONSEQUENCE OF): CARUMOMA OF COLOM WOLTH META STASIS DUE TO (OR AS A CONSEQUENCE OF): CARUMOMA OF COLOM WOLTH META STASIS DUE TO (OR AS A CONSEQUENCE OF): CARUMOMA OF COLOM WOLTH META STASIS DUE TO (OR AS A CONSEQUENCE OF): CARUMOMA OF COLOM WOLTH META STASIS CARUMOMA OF COLOM WOLTH META STASIS DUE TO (OR AS A CONSEQUENCE OF): CARUMOMA OF COLOM WOLTH META STASIS CARUMOMA OF COLOM WOLTH META STASIS CARUMOMA OF COLOM WOLTH META STASIS CARUMOMA OF COLOM WOLTH META STASIS CARUMOMA OF COLOM WOLTH META STASIS CARUMOMA OF COLOM WOLTH META STASIS CARUMOMA OF COLOM WOLTH META STASIS CARUMOMA OF COLOM WOLTH META STASIS CARUMOMA OF COLOM WOLTH META STASIS CARUMOMA OF COLOM WOLTH META STASIS CARUMOMA OF COLOM WOLTH WOLTH META STASIS CARUMOMA OF COLOM WOLTH WOLTH META STASIS CARUMOMA OF COLOM WOLTH WOLTH META STASIS CARUMOMA OF COLOM WOLTH WOLT									
PHYSICIAN: MEDICAL C	PART II. Other algorificent conditiona	contributing to death bu	ACUDE	underlying cause given in	Pert I. 24s. WAS A PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: 1 Inpetient 2 ER/Outpetient 3 DOA 4 Invaring Nome 5 Residence 6 Other (Specify)									
ВУ РН	27. MANNER OF DEATN 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	1	8d. DESCRIBE HOW INJURY OCCURED					
	3 Suicide 6 Could not be datermined	28f. LOCATION (Street City or Town, State	end Number or i	Rural Route Number,						
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICI.	(Check only CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) and menner as stated.								
O BE C	296. SIGNATURE AND TITLE OF CERTIFIER	elle MD.		29c, LICENSE NU			IGNED (Month, Day, Year)			
	30. NAME AND ADDRESS OF PERSON WHO C	Market	Flace ?	undala d	21222 M	10				
	JUL 1 2 1995	102. REGISTRAR'S SIGNAT	URE							

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FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS 220-02-7725 AUG 02, 27 M 2 | F YRS permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give stre 9b. CITY, TOWN OR LOCATION OF DEATH 293 St. Michaels Circle DIRECTOR 0denton RESIDENCE OF DECEDENT 10b. COUNT 10c, CITY, TOWN OR LOCATION Maryland Anne Arundel 0denton 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 293 St. Michaels Circle use as the burial-transit 21113 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES If yes, specify Cuben, Mexican, Puerto Rican, stc.)

1 YES 2 NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION sectly only highest grade complete (Sp detached for Elementary/Secondary (0-12) College (1-4 or 5+) Clerk/Manager 12 Retail once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) James Scott Robinson 2 notified at BE page 5 should 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 James Scott Robinson 293 St. Michaels Ct. Odenton, MD 21113 pe 20e. METHOD OF DISPOSITION
1 Burlel 2- Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must funeral director, Metro Crematory, Inc. 07/11/95 4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. examiner Dawn F. McDonald 299 Frederick Rd. Baltimore, MD 21228 completely filled in by the medicai 23. PART I. Enter the diseees, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. 6 IMMEDIATE CAUSE (Finel the cremation, disease or condition event, resulting in death) Lin executed with DUE TO (OR AS A CONSEQUENCE OF): prior to burial, traumatic CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): has been signed by the attending physician Dept. of Health and Mental Hygiene prior to if any, leading to immediate certificate be e. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated evants resulting in death) LAST 6 injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. PHYSICIAN: MEDICAL any requires Shows DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) MP 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) The Hem THE HOSPITAL OR ATTENDING PHYSICIAN: The THE FUNERAL DIRECTOR: After this certificate hilled within 72 hours after death with the State HOSPITAL OTHER: 1 YES 2 NO Inpetient 2 - ER/Outpatient 3 - DOA ng Home 5 N Residence 8 - Other (Specify) 5 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? marked, 1 Natural 1 YES 2 NO BY 2 Accident investigation 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, atc. (Specify) 9.0 3 Suicide COMPLETED 8 Could not be 4 Homicide 28 Hem 29e. CERTIFIER

(Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. TO THE FUNERAL D be filed within 72 h IMPORTANT: If II (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) end manner as stated. 296. SUCHATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE rose marr 2 PLETED CAUSE OF DEATH (TEM 27) (Type, Print) 15 Anna

James Oscar Robinson

CERTIFICATE OF DEATH

July

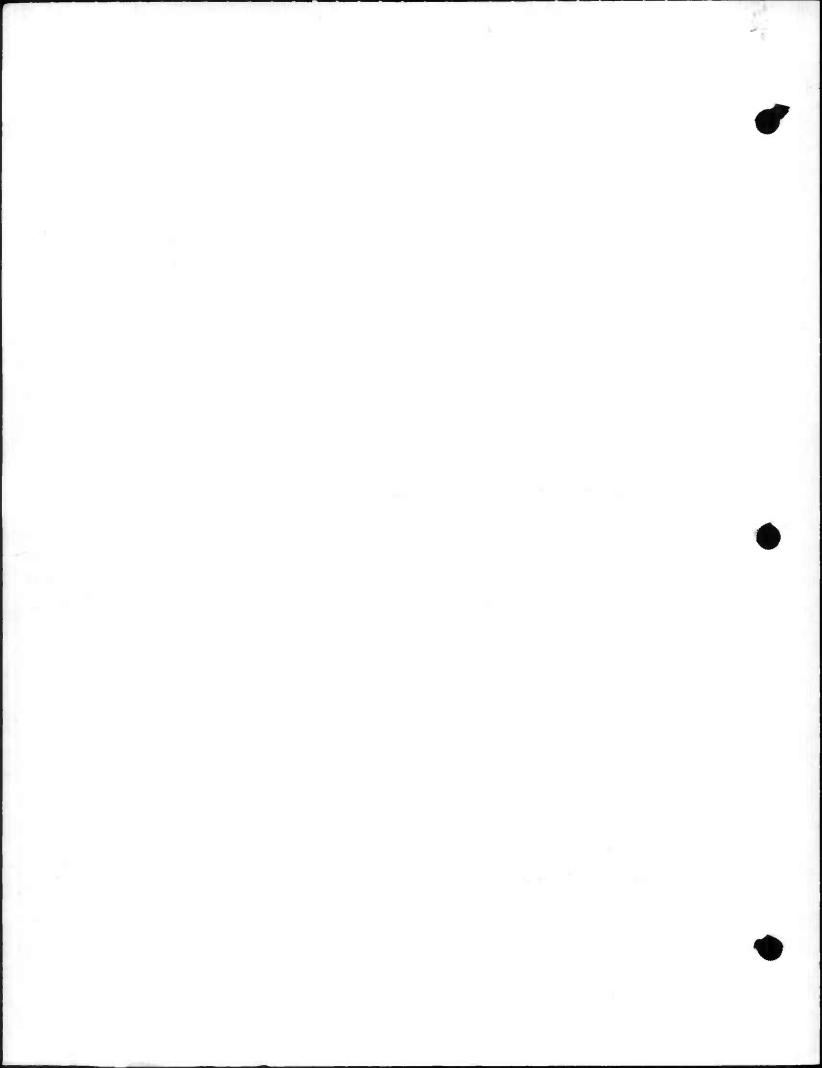
95 20962 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO. 2. DATE OF DEATH 3. TIME OF DEATH YEAR 995 10:40 a M 8. BIRTHPLACE (State or Foreign 1967 Washington, 9c. COUNTY OF DEATH Anne Arundel 10d. INSIDE CITY 1 TYES 2 XNO 16g. CITIZEN OF WHAT COUNTRY? USA 14. RACE — American Indian, Black, White, atc. Specify: Black 16b. KIND OF BUSINESS/INDUSTRY Erika Emilie Hartmann 20c. LOCATION — City or Town, State Baltimore, MD Approximata **Onset and Death** 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF DEATH? 1 TYES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 281, LOCATION (Street and Number or Rural Route Number, City or Town, State)



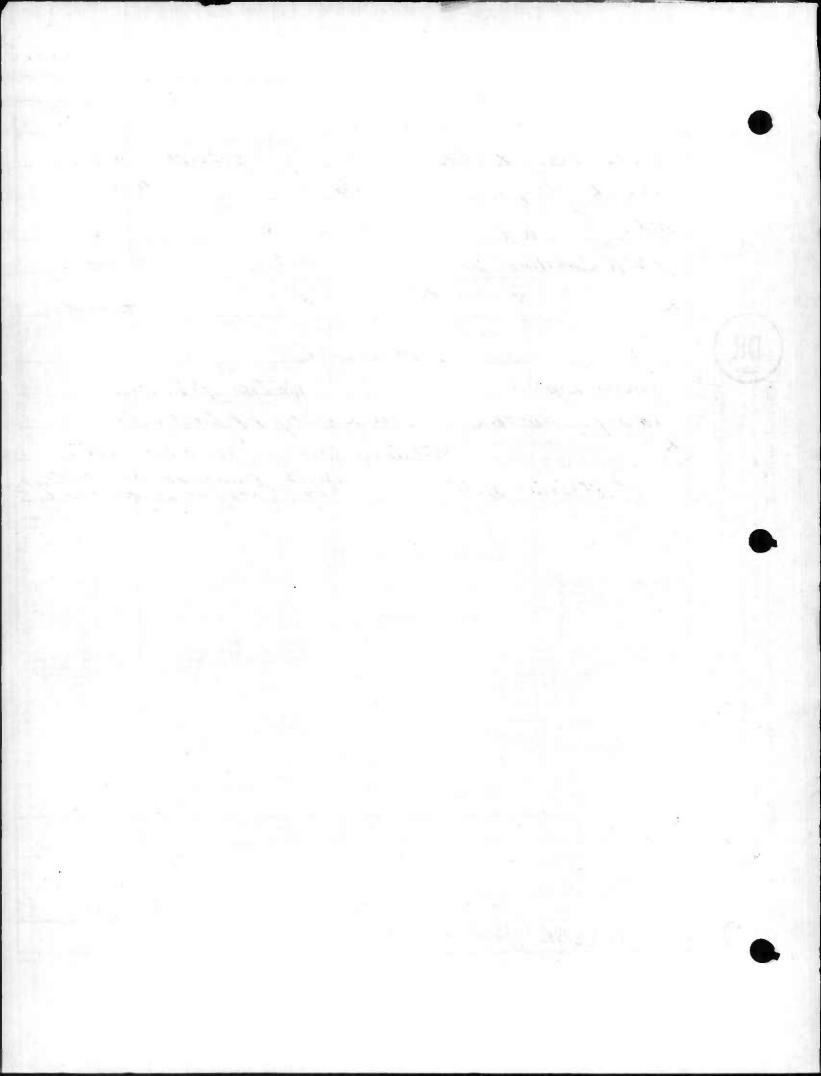
29d. DATE SIGNED (Month, Day, Year)

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		FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	RTMENT OF H	EALTH AND DEATH	MENTAL HYGIEN REG. NO				
		1. DECEDENT'S NAME (First, Middle, Lest)	nmer	VIL			2. DATE OF DEATH	y de	3. TIME OF DEATH		
pie		4. SOCIAL SECURITY NUMBER 218-18-8718	5. SEX 8. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS WIN.	7. DATE OF BIRTH (Month! Day, Year) 5-9-22	C	HATTHPLACE (State or Foreign ountry) Iaryland		
1, 2, 3 should	NERAL DIRECTOR	99. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH NONE RESIDENCE OF DECEDENT NO.									
Pages		Maryland No.	Tone Baltimore					10d. INSIDE CITY LIMITS? 1. YES 2 NO			
an. ransit permit.		2515 Garrison			101	21215		10g. CITIZEN	USA		
A IX 13-00X0 al or attending physician. for use as the burial-transit	BY FUNE	11. MARITAL STATUS 1 Never Merried Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 _ YES IF YES, GIVE WAR OR D	2 NO	If yes, sp		NIC ORIGIN? (Specify Yes in, Puerto Rican, etc.) y:		RACE - American Indian, Black, White, atc.		
pital or atter	PLETED	15. DECEDENT'S EDUC/ (Specify only highest grade of Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+) 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unemployed				16b. KIND OF BUS	SINESS/INDUSTF			
the hospital or detached for u	COMPL	17. FATHER'S NAME (First, Middle, Last)		Jioyea	18. MOTHER'S NA	NO					
# 8 E	H	Benjamin Johnso	on	10h MAH INC	ADDRESS (Complete	Ellen	Charolet	te Mon	teque		
- 2 8 0	5	Harrlene Whitle	ock				Balto.,				
e 6 may rector, pa		20a. METHOD OF DISPOSITION XX Burial 2 Cremation 3 Remote 4 Donation 5 Other (Specify)			OF DISPOSITION (Na		DATE 20c. LO	CATION - City o			
death.		21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE C. XO	nes	Derr 4611	Park H	Jones Fur	neral ve.	Home		
the death certificate be executed within an frours above the attending physician and completely filled in by the Mental Hygiene prior to burial, cremation, or removingury, or other traumatic event, the medical	CERTIFICATION	23. PART I. Enter the disease, or conshock, or heart failure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A REMANDED TO TO TO TO TO TO TO TO TO TO TO TO TO	A CONSEQUENCE OF	k Fail lure	lure			Approximate Interval Between Onset and Death 5 chars 5 days 5 days		
uires that the signed by the Health and M	EDICAL	PART II. Other significant conditions	contributing to death b	ut not resulting	In tha undariying	g cause given in	Part I. 24a. WAS AN PERFOR 1 YES 2	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
The law the has b ate Dept.	SICIAN: MI	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		PF DEATH YE		UNCERTAIN	N D		1 YES 2 NO		
PHYSICIAN this certifi with the s	BY PHYS	1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	4 Nursing Home E OF 28c. INJURY	URY AT	6 Other (Specify) 28d. DE\$CRIBE HOW IN	NJURY OCCURE)		
TTENDI TOR: A after de	ETED B	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	— A1 home, ferm, s	street, factory, office		281. LOCATION (Street a City or Town, State)	and Number or Ru	ral Route Number,		
TAL OR VAL DIRI 72 hour	COMPLE	one) 2 MEDICAL EXAMINEIT:	AN: To the best of my know						se(a) and manner as stated.		
TO THE HOSPI TO THE FUNEF DE filed within IMPORTANT:	TO BE	296 SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CHISE OF DE	ATU (ITEM 27) /Sma	Print	29c. LICENSE NUN	IPS	29d. DATE SIGN	NED (Morth, Day, Year)		
		2-000 X1	3. Bigistan And	PIANTS	2	Alt	MD	2/0	215		
		JUL 1 2 1995 0~	CO STORES	*							



1 3	1. DECEDENT'S NAME (First, Middle, La	Washington	57	AN/-	ha	MO	TE OF OEATH	1	3. TIME OF DEA
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. lest I	birthday) IF UND	ER I YEAR IS ONDER	24 HRS. 7. DA	E OF BIRTH	8.	BIRTHPLACE (State or I
	237-36-072	3 1 M 3 F	82	YRS. MONTH	DAYS HOURS	MIN. (MC	-21-13	3	N.C.
-	9a. FACILITY NAME (If not institution, gi	ive street and number)		9b. Cl	TY, TOWN OR LOCATIO	ON OF OEATH		9c. COUNTY	OF DEATH
CTOR	RESIDENCE OF DECEDENT							119	
DIREC	10a, STATE 10b, COU	JNTY		10c. CITY, TOWN	OR LOCATION				10d. INSIDE CIT LIMITS?
1	10e. STREET AND NUMBER	NIA			101. ZIP CODE			10- CITIZEI	1 VEO 2 N OF WHAT COUNTRY?
ERAL	In 21 N. CAK	aline s	54.		21				1.5,A
BY FUNE	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	T EVER IN U.S. ARM YES 2 PHO	ED 1	3. WAS DECENDENT O			or No— 14	Black, White, atc. Specify:
8	15. DECEDENT'S 8 (Specify only highest gi			EDENT'S USUAL	OCCUPATION to during most of working		16b. KIND OF BUS	SINESS/INDUS	STRY
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COMPL	12. FATOMON'S TRÂME (First, Aliddin, Lapt)	14,777		House		IER'S NAME (Firs	t, Middle, Malden	Surname)	HOME
十二	Lune Lu	inch			N	ettic	Rob	inso	1
IO BI	194. PIFORMANT'S NAME (Sporting	11116	10.7%	MAILING ADDRE	SS (Street and Number	or Rural Route N	umber, City or Town	n, State, Zip Co	ode)
	20a. METHOD OF DISPOSITION	MATTLEN		6800	OSITION (Name of	111	DA	MA CH	y or Town, State
	1 Burial 2 Cremation 3 F	Removal from State		atory of other place		. 7/	750 B	1-146	y or lown, state
	21. SIGNATURE OF FUNERAL SERVICE	E LICENSEE			2. NAME AND ADDRES		//	1 6	(4-1)
	Ratricia Bills Betts Funenal Home								
	23. FART Enter the diseases, shock, or heert failu iMMEDIATE CAUSE (Final disease or condition resulting in death)	or complications that are. List Dnly one ceus	t caused the dea	th. Do not ent	er the mode of dyl	ng, such aa c	ardiac or raspi	ST 10	tt, Approximate interval Onset as
	ahock, pr heert fallu IMMEDIATE CAUSE (Final disease pr condition	a. DUE TO	t caused the dea	UENCE OF):	er the mode of dyl	ng, such as c	ardiec or raspi	ST 1	interval
ERTIFICATION	shock, or heert fally iMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	DUE TO DUE TO d.	coused the dealer in each line. (OR AS A CONSEOUTOR AS A CONS	UENCE OF): UENCE OF): UENCE OF):				Fig. 1	interval
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MEDICAL CERTIFICATION	shock, or heert fallutimed in the shock of t	DUE TO DUE TO DUE TO DUE TO DUE TO HOSPITAL:	coused the dealer in each line. (OR AS A CONSEOUTOR AS A CONS	UENCE OF): UENCE OF): UENCE OF): uence of):	underlying couse of 26. PLACE OF D	piven in Part i.	24a. WAS AN PERFOR	AUTOPSY MED?	24b. WERE AUTOPSY AMAILABLE PRIO COMPLETION OF OF DEATH?
YSICIAN: MEDICAL CERTIFICATION	shock, or heert fallulimmediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) PART II. Other significant conditions of the cause. Examiner? 1 Yes 2 NO 27. MANNER OF DEATH 1 Natural 5 Panding	a. DUE TO	t caused the deal se Dn each line. AG CONSECUTION AS A C	UENCE OF): UENCE OF): UENCE OF): uence of):	underlying couse (26. PLACE OF D	EATH (Check only esidence 6 0 28d. 1	24a. WAS AN PERFOR	AUTOPSY MED?	24b. WERE AUTOPSY AWAILABLE PRIO COMPLETION OF DEATH? 1 YES 2
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BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	shock, or heert fallulimmediate cause or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions in death and investigations. 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation of determine and investigations. Suicide 8 Could not determine and investigations. Suicide 10 CERTIFIER (Check only one) 2 MEDICAL EXAMINER AND TITLE OF CERTIFIER AND T	DUE TO DU	caused the deal see Dn each line. Ag Ca (OR AS A CONSEOU (OR AS	UENCE OF): UENCE	26. PLACE OF D ER: tursing Home 5 Re 25c. INJURY AT WORK? 1 YES 2 sectory, office etims, data and place by opinion, death occur	EATH (Check only esidence 6 0 2 2 3 d. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	24a. WAS AN PERFOR 1 YES 2 The result of th	AUTOPSY MED? MINDER NO NJURY OCCUPANT OF THE SE STATE S	Interval Onset al Onset al J J 24b. WERE AUTOPSY AWAILABLE PRIO COMPLETION OF OF DEATH? 1 YES 2 M
TED BY PHYSICIAN: MEDICAL CERTIFICATION	shock, or heert fallulimmediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted events resulting in death) LAST PART II. Other significant conditions and investigating in death cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted events resulting in death) LAST PART II. Other significant conditions in death can be conditioned in the condition of the cause. Examiner 1	DUE TO DU	caused the deal see Dn each line. Ag Ca (OR AS A CONSEOU (OR AS	UENCE OF): UENCE	26. PLACE OF D ER: tursing Home 5 Re 25c. INJURY AT WORK? 1 YES 2 sectory, office etims, data and place by opinion, death occur	EATH (Check only esidence 6 0 2 2 3 d. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	24a. WAS AN PERFOR 1 YES 2 Ther (Specify) DESCRIBE HOW II OCATION (Street & lift) or Town, State)	AUTOPSY MED? MINDER NO NJURY OCCUPANT OF THE SE STATE S	Interval Onset as Onset as J J 24b. WERE AUTOPSY AVAILABLE PRIO COMPLETION OF OF DEATH? 1 YES 2 RED Rural Route Number, cause(e) and manner see

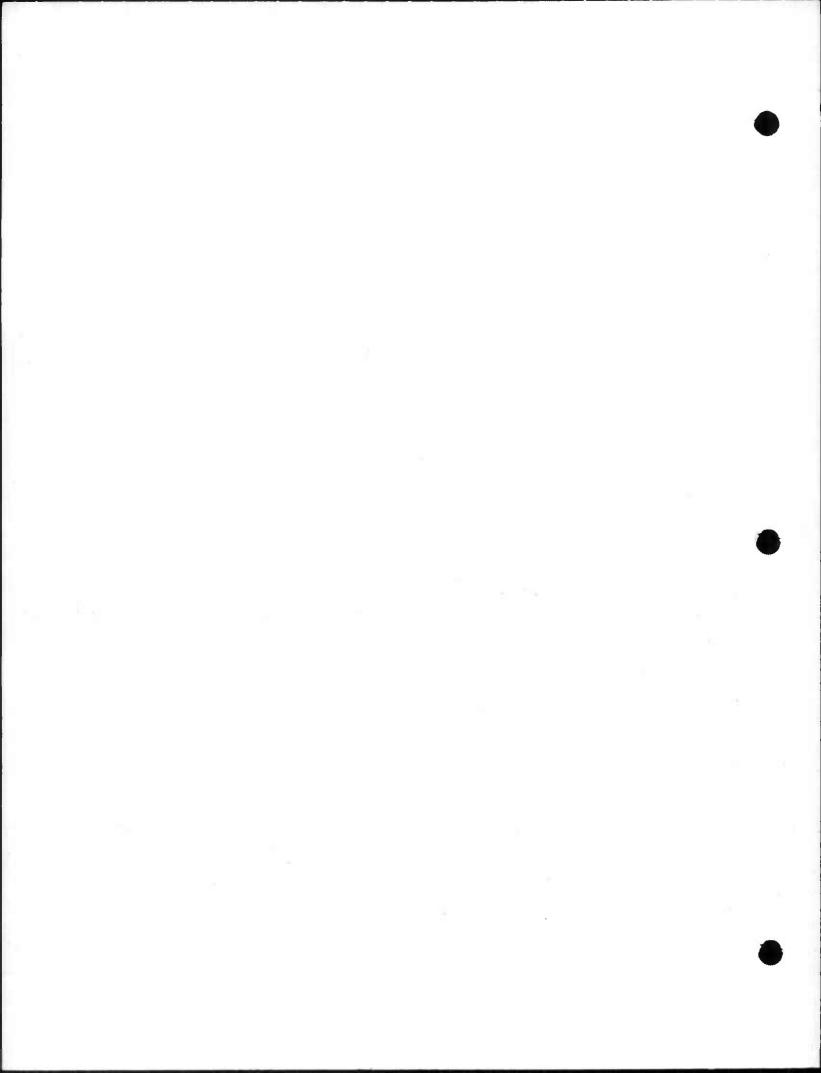


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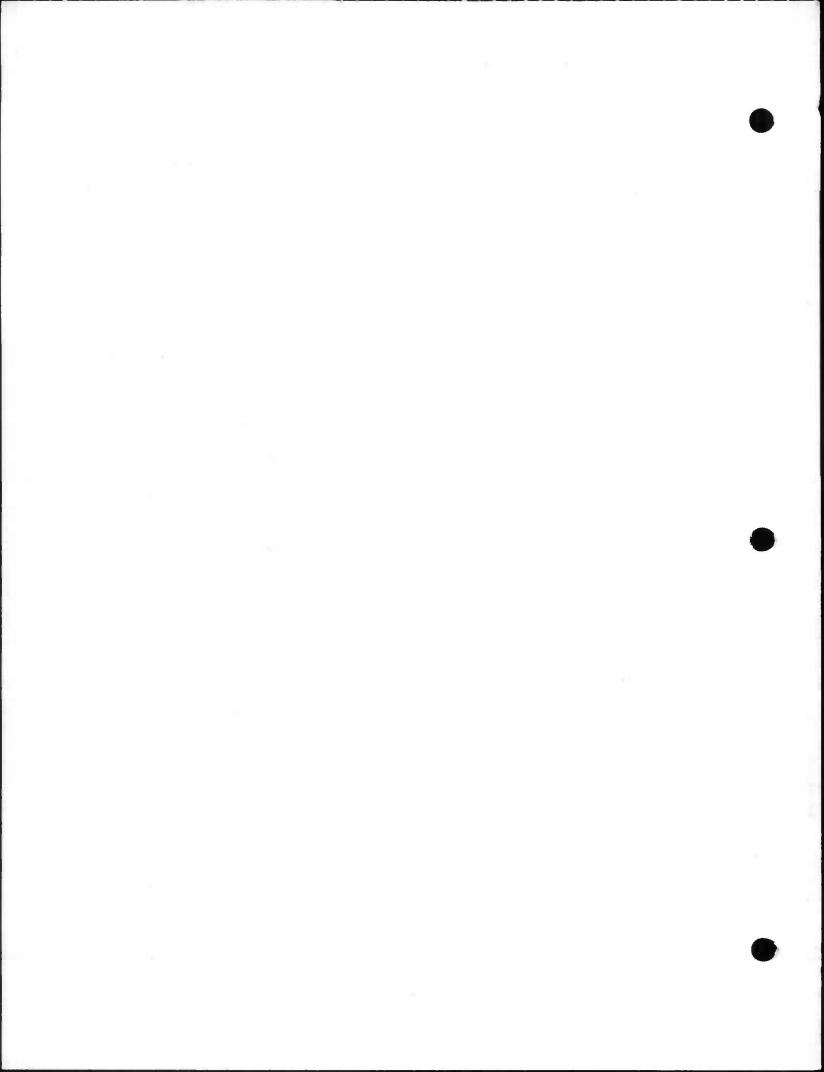
DIVISION OF VITAL RECORDS, P.O. BO)

THE INVESTIGATION PRODUCTION OF THE PRODUCTION O	IV THE MUSY LALL OF ALL ENDING PHYSICIAN: THE LAW FEBRURES that the OBJOIN CONTINUES THE OBJOIN CONTINUES THE MUSY LALL OF TH	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1.2.3 should	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
2001 2112 00	O THE HOST	THE FUNE	e filed within	MPORTANT	

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMEN	T OF H	IEALTH DE AT	AND I	MENT/	AL HYGIE			
	1. DECEDENT'S NAME (First, Middle, Last)				- 01	DEA			E OF DEATH			3. TIME OF DEATH
	Mildred Juli	ia Swem						MON T11 T	7 10,	1995	YEAR	8:50a M
	4. SOCIAL SECURITY NUMBER	IF UNDER		IF UNDER		7. DATE OF BIRTH (Month, Day, Year)			8. BIRTI	IPLACE (State or Foreign		
	219-10-0301 1 89 YRS. 89 YRS.						18,	1906		RYLAND		
~	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH										EATH	
0	12219 Falls Roa	1d			COCK	EYSV	TLLE			BA	LTIM	ORE
E I	10a. STATE 10b. COUNTY		10c, CI	Y. TOWN (OR LOCAT	ION						10d. INSIDE CITY
DIRECTOR	MARYLAND BALT		OCKE	YSVI	LLE						LIMITED NO	
	10e. STREET AND NUMBER				101	. ZIP CODE		_		10g. CITI	ZEN OF N	WHAT COUNTRY?
FUNERAL	12219 Falls F	Road				2103	0				USA	
5		12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13.	WAS DEC	ENDENT O	F HISPAN	IC ORIG	N? (Specify Y	es or No-	14. RACI	E — American Indian, k, White, stc.
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA				2 110			Rican, atc.)		Spec	My:
	15. DECEDENT'S EDUCA	FION	44 050505050							!		HITE
	(Specify only highest grade of Elementary/Secondary (0-12)	(mpleted)	(Give kind of life. Do NOT u	work done	during mo	st of working	g	16	b. KIND OF B	USINESS/IND	USTRY	
2	7	College (1-4 or 5+) n/a		mema					Own H	lome		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			-		18. MOTH	IER'S NAI	ME (First.	Middle, Maide	n Sumame)		
BE C	Benjamin J. Fo	rwood				С	ora	J.Tl	nompso	n		
10	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS	S (Street a	nd Number	or Rural F	Route Nun	nber, City or R	wn, State, Zip	Code)	
-	Louise Fox Hawk		12219	Fal	ls R	ld.,	Cock	eysv	ville,	MD 2	1030	
	20c. METHOD OF DISPOSITION Surial 2 Cremation 3 Removal from State 20c. LOCATION - City or Town, State 1.7											
	4 Donation 6 Other (Specify) Crace U. Meth. Church JULY COCKEYSVILLE, MD											
	22. NAME AND ADDRESS OF FACILITY Lemmon Funeral Home of Dulaney Valley Inc.											
	Bryah	W.Clary	1									21093
	23. PART I. Enter the diseasea, or co	mplications that coused	the death. Do	not enter	tha mo	de of dyi	ng, such	aa cei	diac or res	piratory arr	est,	Approximata
	shock, or heart feliure. List only one cause on each line. Interval Between Onset and Death											
	disease or condition resulting in death) a.	DUE TO (OR AS A	PU/MC?	1021	9	0	ne	14				
		DUE TO (OR AS A	CONSEQUENCE O	F):	/							
ON	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):											
AT.	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OH AS A CONSEQUENCE OF):										
	CAUSE (Disesse or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE O	F):								
CERTIFICATION	resulting in death) LAST											
	PART ii Other significant conditions											
SAL	PART ii. Other significent conditions	contributing to deeth bi	ut not resulting	in the un	ideriying	ceuse g	iven in l	Part I.	24a. WAS A PERFO	N AUTOPSY PRMED?	24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDIC									1 TYES	2 1 10		OF DEATH?
	DID TORACCO HEE CONTROL	BUITE TO CALLES O	E DE ATIL NO									1 TYES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTRI		F DEATH YE			UNC	ERTAIN	1 🗆				
S	EXAMINER?	HOSPITAL:		OTHER	₹:	_/	/				-	
¥	27. MANNER OF DEATH	28a. DATE OF INJURY	28b, TIM	- v	28c. tNJI	5 TRes	sidence		F (Specify) SCRIBE HOW	IN HIRW OCC	HIDED	
	1 Netural 5 Pending	(Month, Day, Year)		URY M	WO		NO	200. DE	SCHIBE HOW	INSURT OCC	UNED	
BÝ	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY	— At home, farm,	street, fact				28f. LO	CATION (Street	and Number	or Rural F	loute Number.
Ä	4 Homicide determined	building, atc. (Speci	ify)					City	or Town, State	9)		,
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSICI	AN: To the best of my knowle	edge, death occurr	ed at the ti	me date	and place	and due	to the co	use(s) and m		4	
ğ		On the basis of examination										and manner sa stated.
U C	296. SIGNATURE AND TITLE, OF CERTIFIER	/1//				29c. LICEI						(Month, Day, Year)
00	Misut Sh	alt M.)			.) ,	09			DATE	- SIGNED	(MOIRII, Dely, Tear)
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type	Print)		1)	シファ	, ,			// 4	-//3
	Robert B. Stotz	M.D. 1447	York Ro			. Ans	Т	+h -	mrr 2 1 1	1/17	2100	2
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	TURE		MILE.	. 005	a Lil	rrne.	LVILLE	MIU	71119	3
	JUL 1 2 1995 /4	un diffusion has	dall									



		1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF I			GIENE G. NO.		
	300000	1. DECEDENT'S NAME (First, Middle, Last) CHARLES	James		ROM	ER	2. DATE OF DE	DAY	YEAR 1.15 PM	
pin		4. SOCIAL SECURITY NUMBER 215-10-4720 90. FACILITY NAME (If not institution, give	1-FM 2 - F	In yrs. lest birthday)	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		, 1907	BIRTHPLACE (State or Foreign Country) MARYLAND	
2. 3 should	FOR	Charlestown Ca				OR LOCATION OF DI	EATH		V OF DEATH LTIMORE	
←	DIRECTOR	10e. STATE tob. COUNT			TY, TOWN OR LOCA			10d. INSIDE CITY		
permit. Pages		10e. STREET AND NUMBER				H. ZIP CODE			1 TYES 2 NO	
an. transit	FUNERAL	711 Maiden	12 WAS DECEDENT EVED IN	U.S. ARMED	13. WAS DEC	212 CENDENT OF HISPAI	228	USA	I. RACE — American Indien,	
ัก ก)	PIBY F	t Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES	2 V NO ATES	It yes, sp	pecify Cuben, Mexice 3 2 NO Specif	n, Puerto Ricen,	etc.)	Black, White, atc. Specify: WHITE	
	Ships Ships	15. OECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		18a. DECEDENT'S (Give kind of life. Do NOT u	S USUAL OCCUPATI work done during ma ise retired.)	ON ost of working	16b. KIND	OF BUSINESS/INDUS	TRY	
AND he house detached detached	сомы	12 17. FATHER'S NAME (First, Middle, Last)	n/a	Audit	or	10 MOTHERIE MA		el Indust	try	
YLA obythe dator	BE CC	Henry Stro	mer			18. MOTHER'S NA	Spahn	Maiden Sumeme)		
MARYLAND retained by the hospil 5 should be detached notifiled at once.	TO B	19a. INFORMANT'S NAME (Type/Print) Elizabeth Blan	nton					or Town, State, Zip Co		
RE, may te r, page		29e. METHOD OF DISPOSITION 1 Suriel 2 Cremetion 3 Rem	count tones Carrie	PLACE AND DATE	OF DISPOSITION (N.	ame of	DATE	um, MD 21		
IMORI Page 6 ma Il director, p		4 Donation 5 Donat (Specify)) D11	laney Va	lley Me	m. Gardens		Timoniu	m, MD	
		Lowell	Lemmon	_	10 W.	Padonia	Rd., T	imonium.	y Valley, Inc. MD 21093	
ours or rer			complications that caused List only one cause on as	the daath. Do ach lina.	not antar the mo	oda of dying, suc	h aa cardlac D	r reapiratory arres	t, Approximate interval Between Onset and Daath	
760. No with the opposite of t		IMMEDIATE CAUSE (Final disease or condition resulting in death)	. Chronic () bituil	two Pril	monoy	Diseo	sl .	Ylon	
N 8 5 - 0	Z	Sequentially list conditions,	b.	CONSEQUENCE O)F):					
De e cian a lor to	CATIC	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE O	PF):					
S, P.O. Bedeath certificate attending physieme pressure in thygiene pressure, or other the	CERTIFICATION	CAUSE (Disease or injury that initiated events reaulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE O	PF):					
0 2 3 3		PART ii. Other algnificant condition	d	ut not resulting	in the underlyin	o causa nivan in	Dart i 24a 1	MAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS	
2 5 5 m	MEDICAL	X 9 - 900	mention			g casa gran m	9	YES 2 NO	AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?	
AL RECOP he law requires that has been signed to bept. of Health at 23 shows any		DID TOBACCO USE CONT	RIBLITE TO CAUSE O	F DEATH Y	ES II NO I	UNCERTAIN	U M		1 TYES 2 NO	
VITAL IAN: The law tificate has be State Dept.	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			TH (Check only one)		M M			
S and S	HYSI	1 VES 2 NO 27. MANNER OF DEATH	1 ☐ Inpatient 2 ☐ ER/Outp	28b. TIN	4 Nursing Hon IE OF 28c. IN.	ne 5 Rasidence		HOW INJURY OCCUP	BED	
ON OF DING PHYSIC After this cer death with th s marked, c	ву р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)		M 1	YES 2 NO				
TOR: after	ETED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Speci	— At home, term,	street, factory, offic	:0	281. LOCATION City or Town	(Street and Number or n, State)	Rural Routa Number,	
Z ZZ =	COMPL		ICIAN: To the best of my knowless: On the basis of examination							
물 물 을 통	8	29b. SIGNATURE AND TITLE OF CERTIFIE	> lul-			29c. LICENSE NUR	1BER 473	29d. DATE S	HIGNED (Morrith, Day, Year)	
₽ ₽ # ¥	2	30, NAME AND ADDRESS OF PERSON WH	11					- yw	21278	
10		31. DATE FILED (MONTH), DONA YOUR 100	32-PEGSTHALL SIGN	10 71	MAID	EN CHO	ILE !	CA, BAL	TIMORE, MD	
10		JUL 1 % 199	2) Home or man	workerfall						

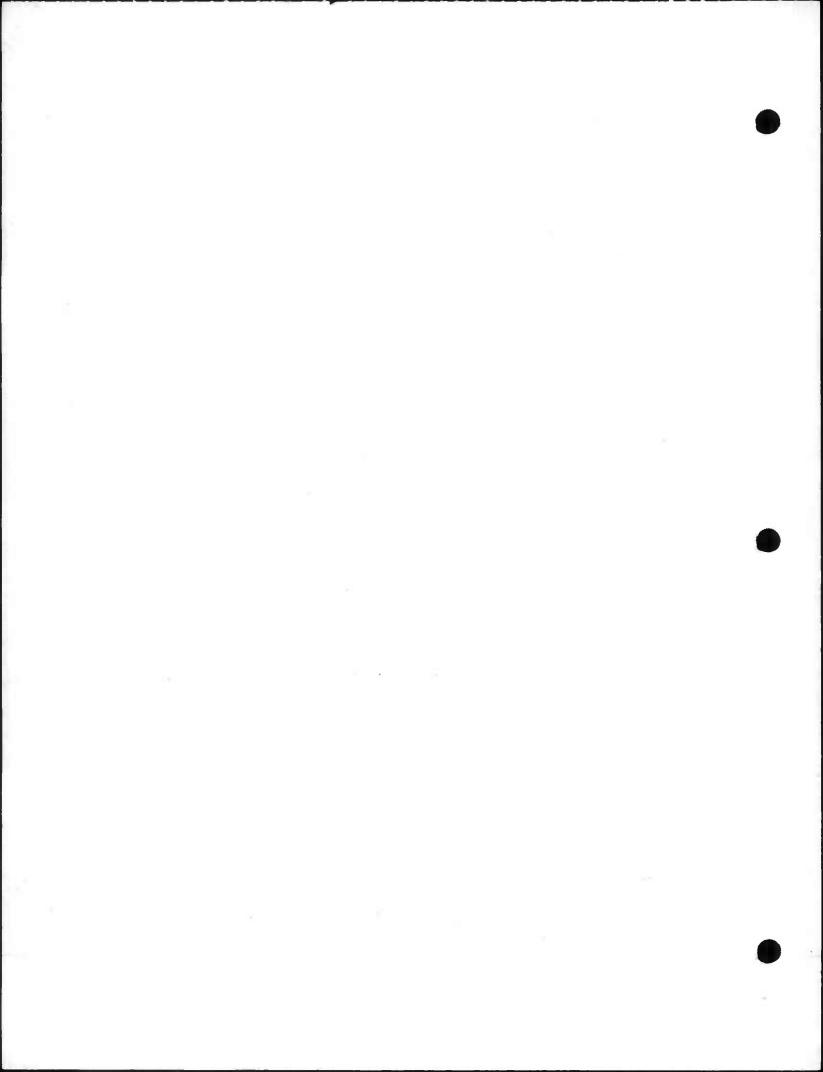


DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within any hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, certainly, or removal.

	-	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
		1. DECEDENT'S NAME (First, Middle, Last)	Tevens					2 / SS	3. TIME OF DEATH	
		4. SOCIAL SECURITY NUMBER 5			UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8,1	BIRTHPLACE (State or Foreign Country)	
		9e. FACILITY NAME (If not institution, give stree	/		CITY, TOWN	OR LOCATION OF D	6/10/0 EATH	9c. COUNTY	OF DEATH	
TOR		GREENDE IT NURSUS CENTER GREENBOIT Md PG								
DIRECTOR	DIRE DIRE	MARYLAND Princ	e Georges	10c. CITY, TO	WN OR LOCA	TION	MIN		10d. INSIDE CITY LIMITS? 1 TES 2 NO	
	- 11	100. STREET AND NUMBER 4521 OMG V			10	1. ZIP CODE	4	10g, CITIZEN	OF WHAT COUNTRY?	
FUNERAL	EIED OT	11. MARITAL STATUS 12	2. WAS DECEDENT EVER IN FORCES? 1 YES				NIC ORIGIN? (Specify Year, Puerto Ricer, etc.)	e or No — 14.	RACE — American Indien, Black, White, etc.	
B M		1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA			3 2 NO Specif			Specify: B/ACK	
ETED		15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12)	ION npleted) College (1-4 or 5 +)	16e. DECEDENT'S USU (Give kind of work life. Do NOT use refi	done during me	ON ost of working	16b. KIND OF BU			
once.		12 th GRACE 17. FATHER'S NAME (First, Middle, Last)		Home	nak	Ÿ —	IN	Home	2	
TO BE COM		James Stevens				16. MOTHER'S NAME (First, Middle, Meiden Surname) Elijah Smith				
TO E	- 11	DR. Ralph E. Gil	reen	39 17	LCYC		Route Number, City or Tox	on, State, Zip Coo		
onst be		20e. METHOD OF DISPOSITION 1		PLACE AND DATE OF DI			DATE 20c. LC	CATION - CHY	or Town, State	
examiner must		21. SIGNATURE OF FUNERAL SERVICE LICEN		THEON		ND ADDRESS OF FA	-	30 35	ST.N.W	
ai exam		Ri-State Funeral Services INC								
e medicai	23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel								Approximata Interval Between Onset and Death	
event, the		disease or condition resulting in deeth)		consequence of:	Info	retion		_	-	
		Sequentially list conditione, DUE TO (OR AS A CONSEQUENCE OF):								
		CAUSE (Disease or injury								
ry, or other CERTIFIC		thet initieted eventa DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST d								
AL Into		PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY PERFORMEDY PERFORMEDY AMALABLE PRIOR TO COMPLETION OF CAUSE								
shows and	İ	Stole To dr.	0.000	, 62.			1 YES :	2 1 NO	COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
23 AN		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED-TO MEDICAL 26. PLACE OF DEATH (Check only/one)								
Si Ital		EXAMINER? 1 YES 2 NO	OSPITAL:	OT	HEA:	e 5 🗆 Residence	6 Other (Specify)			
marked, or BY PHY		27. MANNED OF DEATH 1 Netural 5 Pending 2 Accident Investigation	25e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJ W0	PRK?	28d. DESCRIBE HOW	INJURY OCCURE	D	
S IS		3 Suicide 6 Could not be 4 Homicide detarmined	28s. PLACE OF INJURY - building, atc. (Specif	At home, farm, street	, factory, offic	a	251, LOCATION (Street City or Town, State		ural Route Number,	
item PLE	ı	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end menner as stated.								
MPORTANT: If Ite		2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date and placa, end due to the ceuse(e) end manner ee stated, 29b. SIGNATURE AND TITLE OF CERTIFIER								
IMPOR TO BE		Dald. 4 - 1 coverid attendid 220079 1 6/30/85								
		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (TYPE, PRINT) DOS H. Yabloson. L. MD 7404 Executive Pl., F222, Jealres MD 21704								
		JUL 1 2 1995	HE STEET FREE CO	WRE				÷		



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	NEGISTRAN		CE	RIIF	CALE	UF	DEA	I III	REG. N	0			
	1. DECEDENT'S NAME (First, Middle, Last) DOROTHY	ALICE		STEIN	BACH	ÆR			2. DATE OF DEATH MONTH	DAY 1 995	YEAR	3. TIME OF DEATH 4:25 am M	
- 3	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. las	t birthday)	IF INDER	NDER t YEAR IF UNDER 24 HRS.			7. DATE OF BIRTH		La gierri	IPLACE (State or Foreign	
ĺ	313-09-9113	1 🗆 M 2 🔀 F	88	YRS.	MONTHS	DAYS	HOURS	MIN.	11/26/06	5	Indi	ry)	
E E	90. FACILITY NAME (If not Institution, give s Saint Joseph Medic							ON OF DEA			altimo		
K	RESIDENCE OF DECEDENT				i								
Ĭ,	10a. STATE 10b. COUNT			10c. CIT	Y, TOWN OF	R LOCAT	ION					10d. INSIDE CITY	
DIRECTOR	Maryland Bal	timore		T	'owsor	-						t TYES 2 1 NO	
FUNERAL	8617 Pleasant Pl	ains Road	a .			101	. ZIP CODE	E 2128€	5	10g. CI1	10g. CITIZEN OF WHAT COUNTRY?		
3	11. MARITAL STATUS	EVER IN ILS. AR	MED	13. W	AS DEC			C ORIGIN? (Specify Y	na or No				
	1 Never Married 2 Merried	FORCES? 1 IF YES, GIVE W	YES 2 N	10	H	yes, spe	ecify Cube	n, Mexicen,	Puerto Rican, etc.)	01 IVO —		E — American Indian, k, White, etc.	
ВҰ	3 XWidowed 4 Divorced	IF TES, GIVE W	AH OH DATES		1 ☐ YES 2 X NO Specify:						Speci	White	
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working										MILCC		
ш	(Speciny only nignest grade Elementary/Secondary (0-t2)	College (1-4 or 5 +	Man	ve kind of v Do NOT us	work done du se retired.)	uring mo	st of workin	g					
집	A production of the second of	years		nerv	isor				F	ende	c Cor	.a.	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	70020		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1001		16. MOTH	IER'S NAM	E (First, Middle, Maide			P	
	William Harrison	Gross							e Ann Gob			N	
BE	19a. INFORMANT'S NAME (Type/Print)	CLODD	198	. MAILING	ADDRESS	(Street a			oute Number, City or To		in Corte)		
2	Dorothy Leight		1.00							wson		21286	
	20e. METHOD OF DISPOSITION		20b. PLACE A					ains		OCATION -			
	1 Buriet 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)		Dular	natory or of	alley	, M∈	em. G	ar.	7/12/95	Cocke	eysvi	lle, MD	
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	11/					S OF FACI	al Home				
	Christin	201	Kapa	48	85	521	Loch	Rave	en Blvd.	Tows	son,	MD 21286	
	23. PART I. Enter the diseases, or o	complications that	coused the de	ath. Do n	ot enter t	he mo	de of dyl	ng, such	as cardiec or rea	piratory ar	rest,	Approximate	
H	ahock, or heart fellure. IMMEDIATE CAUSE (Finel	List only one caus	se on eech line.									Onset and Death	
	resulting in death) PROBABLE CARDIAC ARRHYTHMIA												
	DUE TO (OR AS A CONSEQUENCE OF):												
No.	Sequentielly liet conditions, ASPIRATION PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF):												
EDICAL CERTIFICATION	or conditions and the conditions of the conditio												
윤	CAUSE (Disease or Injury thet initiated events DUE TO (OR AS A CONSEQUENCE OF):												
E	resulting in deeth) LAST	4											
2													
¥	PART II. Other significant condition	a contributing to	deeth but not n	eaulting i	n the und	leriying	ceuse g	iven in P		N AUTOPSY	24b.	. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO	
ă	-								YES YES	2 🗌 NO		COMPLETION OF CAUSE OF DEATH?	
¥.									_			YES 2 NO	
z	DID TOBACCO USE CONTI	RIBUTE TO CAL	JSE OF DEAT	TH YE	S 🗆 N	0 🗆	UNC	ERTAIN					
8	25. WAS CASE REFERRED TO MEDICAL		26. PLAC	E OF DEAT	'H (Check or								
is I	1 YES 2 NO	OSPITAL:	ER/Outpatient 3	□ DOA	OTHER:		e 5 🗆 Re	sidence 8	☐ Other (Specify)				
PHYSICIAN:	27 MANNER OF DEATH Natural 5 Pending	26e. DATE OF I (Month, Da		26b. TIMI INJ		86. INJU			28d. DESCRIBE HOW	INJURY OC	CURED		
D BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF	INJURY — At hor	ne, farm, s	treet, fector				28f. LOCATION (Street		or or Rural F	Poute Number,	
COMPLETED	4 Homicide determined		All (opposity)						City or Town, State	"			
릴		CIAN: To the best of r											
Į į	2 MEDICAL EXAMINE	R: On the beele of ex	mination end/or in	rveatigatio	n, In my opi	Inlon, de	eath occur	ed at the tir	me, date end place, e	nd due to ti	he ceuse(e) end menner ee stated.	
BE	295. BIGNATURE AND TITLE OF CENTIFIER	1	(M)	1		\Box	-	NSE NUMB	ER	29d. DAT	E SIGNED	(Manth, Day, Year)	
10	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUS	- NV) .	D-(-4)		D 06	234		1	1/10	193	
	SAMUEL C. LEE, M.					N,M	ARYLA	ND 2	1204		•		
	31. DATE FILED (Month, Day, Year)	32 REGISTRAF	'S JIGNATURE										
	JUL 1 2 1995 Ju	ry agmajor	wardally.										

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DIVISION OF VITAL RECORDS,	The second secon
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE - STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Lest)

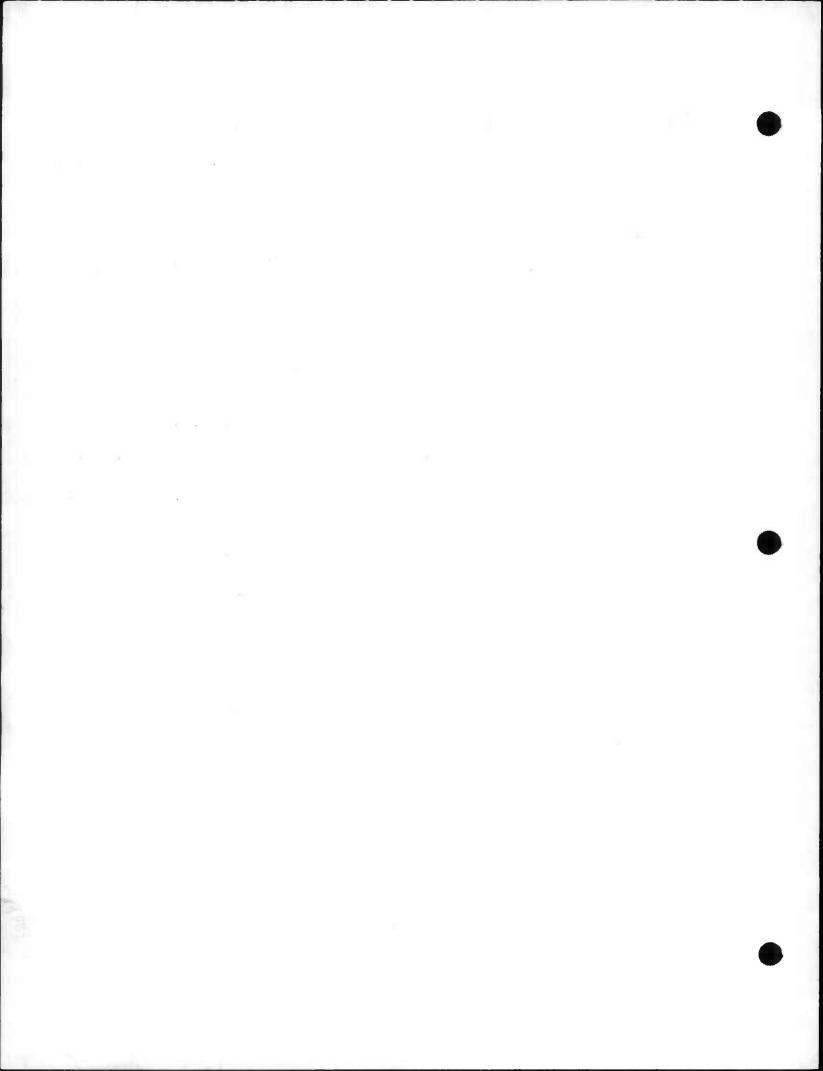
- 1/10 . Smit CERTIFICATE OF DEATH REG. NO 2. DATE OF DEATH 3. TIME OF DEATH 995 12:00 A. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF IF UNDER 1 YEAR IF UNDER 24 HRS. HIR 8. BIRTHPLACE (State or Foreign HOURS 1 M 2 F YRS. 243-18-8614 Mar. 20 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Liberty Medical Center Baltimore 10a. STATE 10b, COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md Baltimore 1 T YES 2 | NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician, and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit 2808 Mosher Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Narried BY 3 Widowed 4 Divorced Black COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 6th laborer Millwork 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) F BE Henry Smith Charity Taylor notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Horace Smith Dukeland Durham, 2 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata must DATE etery, crematory or other place) 4 Donation 5 Other (Specify) 7/14/95 Lakeland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Wainwright Funeral Home Wainwright Funeral Home 2700 Edmondson Ave. Balt 22 Part I. Enter the diseases, of complications that caused the deeth. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one ceuse on sech line. Ave. Balto. 21,22 Md medicai completely filled in by rial, cremation, or remo **Approximate** Interval Between IMMEDIATE CAUSE (Final **Onset and Death** the disease or condition Myocandial IN Farction event. resulting in death) DUE TO (OR AS A CONSEQUENCE OF): and com ar ardiac traumatic CERTIFICATION Sequentially list conditions, attending physician a DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING 2 andlomyopa certificate CAUSE (Disease or Injury other that initiated eventa resulting in death) LAST alr 50 death (n signed by the attend Health and Mental H any Injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS requires that AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Shows 1 YES 2 NO Deen 6 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. s certificate has the the State Dept 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) The Item **EXAMINER?** HOSBITAL: OTHER 1 YES 2 NO OR ATTENDING PHYSICIAN: 1- Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) the 6 27. MANNEB OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED this c marked, 1 Natural 1 YES 2 NO death BY After 2 Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 99 3 Suicide 281. LOCATION (Street and Number or Rural Routs Number, City or Town, State) ETED 8 Could not be determined DIRECTOR: / 4 Homicide 28 O THE HOSPING.
TO THE FUNERAL DIRECTOR
TO THE FUNERAL DIRECTOR
TO THE HOSPING TO THE HOSPING THE HOSPI Hem 29a. CERTIFIER
(Check only

1 CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. COMPL 2 MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Yber)

July 10 +11 1995 BE brance 8. dank mo 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Bultimae RTANCE alals 31. DATE FILED (Month, Day, Year) 32. REGIŞTRAR'S SIGNATURE

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	END	ter d	89
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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by ***	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detail be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at one

permit. Pages 1, 2, 3 should

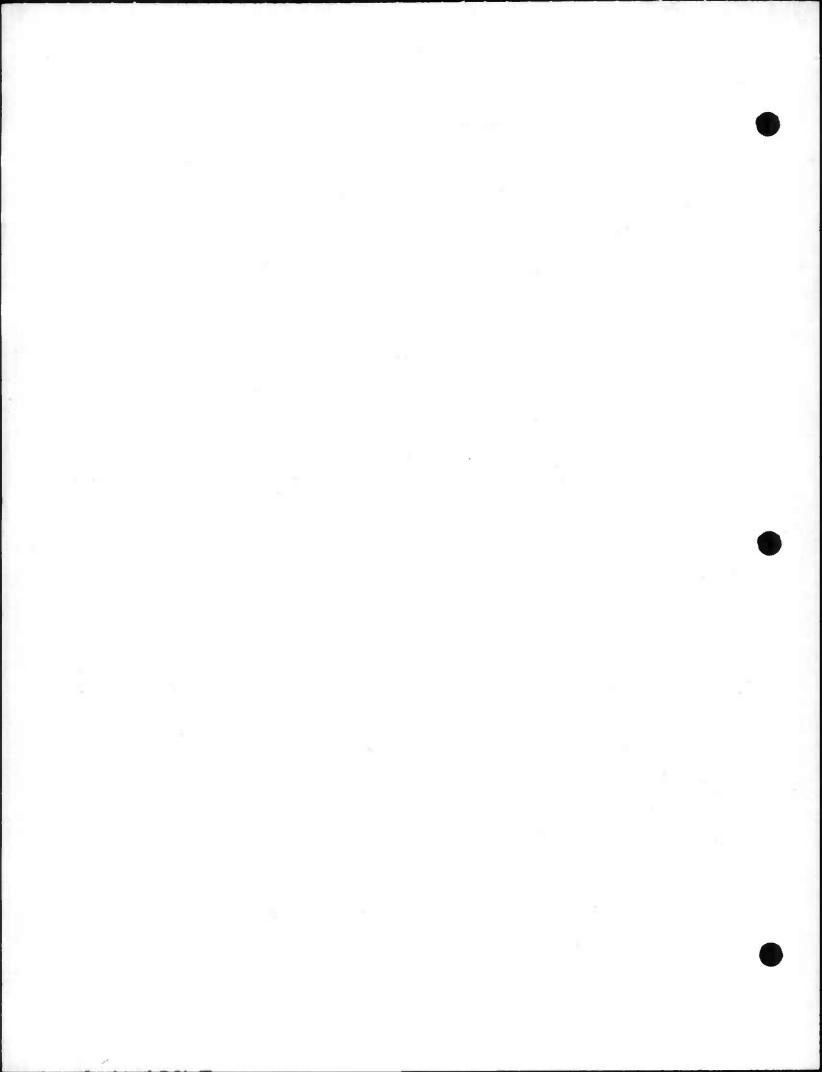
	1 - FOR STATE REGISTRAR	STATE OF M	ARYLAND /	DEPART	MENT OF I	HEALTH AND	MENTAL HYGIEN				
710 441	1. OECEDENT'S NAME (First, Middle, Last) JAMES	т.		SAND			2. DATE OF DEATH	AY YEA			
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	st birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	A BI	RTNPLACE (State or Foreign		
	217-09-4418 9e. FACILITY NAME (If not institution, give s	XX M 2 F	85	YRS.	ONTHS DAYS	OR LOCATION OF O	JUN 8, 19	10 F	BALTIMORE, MD		
DIRECTOR	THE JOHNS HOPKIN		L		BALITMORE CITY n/s						
E	10e. STATE 10b. COUNTY			10c. CITY,	TOWN OR LOCA				10d. INSIDE CITY		
	MARYLAND 100. STREET AND NUMBER	n/a			BALTI	MORE			1 YES 2 NO		
VERA	1830 ASHLAND AVENUE					21205		UNITEI	STATES		
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Maried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. A FORCES? 1 X WES 2 F YES, GIVE WAR OR DATES 13. WAS DECEDENT EVER IN U.S. A				If yes, so	CENDENT OF NISPAN ecity Cuban, Maxica 2 No Specify	te or No— 14. RACE — American Indien, Black, White, etc. Specify: BLACK				
是	15. DECEDENT'S EDUC (Specify only highest grade	CATION corripleted)	(G	ive kind of wo	SUAL OCCUPATI	ON ost of working	16b. KIND OF BU	SINESS/INDUSTR	,		
COMPLETED					retired.) DRIV		BAG	Comp:	PANY		
00	17. FATHER'S NAME (First, Middle, Last)			7		18. MOTHER'S NA	ME (First, Middle, Maiden	Surname)			
BE	WILLIAM SAU 19s. INFORMANT'S NAME (Type/Print)	INDERS	1 40	MAN MO A		ADA	HAYES				
5		IDERS	19	1830	ASHL		Houte Number, City or Tow		ARYLAND é05		
	20e. METNOD OF DISPOSITION 1 X Burlet 2 Cremation 3 Remo			AND DATE OF	DISPOSITION (N	eme of C	emetery 20c. LO	CATION City or	Town, State		
	4 Donetion 5 Other (Specify)	ENSEE	GAI	RRISON	FORES	ST VA CE		L2 OWING	S MILLSMD		
	of Valence	ia No	elan	d			FH1101	E. NORT	H AVE.		
	23. PART I. Enter the diseases, or cahock, or heart fellure.	oniplications that	caused the de	ath. Do no	enter the mo	de of dylng, sucl	h aa cerdlac or respi	iratory arrest,	Approximata Interval Between		
	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Hallaclem i a 3hours										
_	-	170	OR AS A CONSEC	DUENCE OF):	we.	-			12hax		
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING		OR AS A CONSEC	SEOUENCE OF):							
SE	CAUSE (Disease or Injury that initiated events	DUE TO	OR AS A CONSEC	DUENCE OF):					laay		
E	resulting in death) LAST	1/h	erm	me	2				Ldays		
AL C	PART II. Other significant condition	s contributing to d	leath but not r	esulting in	the underlyin	g ceuse given in	Part I. 24s. WAS AN		4b. WERE AUTOPSY FINDINGS		
3	large Cell	1914	hon	la			1 YES 2		COMPLETION OF CAUSE OF DEATH?		
PHYSICIAN: MEDIC	DID TOBACCO USE CONTR	DIRLITE TO CAL	ISE OF DEA	TH VEC	□ NO N	LINICEDTAIN			1 TES 2 NO		
NA I	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				(Check only one)	UNCERTAIN	<u>ч </u>				
YSIC	1 TES 2 NO	HOSPITAL:	ER/Outpatient 3		THER: Nursing Hore	e 5 🗆 Residence	8 Other (Specify)				
ВУ РН	21 MANNER OF DEATN 1 Matural 5 Pending 2 Accident Investigation	28a. DATE OF II (Month, Day		28b. TIME (Y WC	URY AT PRK? YES 2 NO	28d. DESCRIBE NOW I	NJURY OCCURED			
	3 Suicide 8 Could not be determined	28e. PLACE OF building, at	INJURY At ho	me, farm, stri	et, factory, offic		28f. LOCATION (Street of City or Town, State)		al Route Number,		
COMPLET	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of m	ly knowledge, de	eth occurred	at the time, date	end place, and due	to the cause(e) end men	nner as stated.			
8			mination and/or I	nvestigation,	in my opinion, d	eath occured at the	time, data and placa, an	d due to the caus	e(e) and menner as stated.		
TO BE	296. SIGNATURANTO TITLE OF CERTIFUE	29c. LICENSE NUMBER				29d. OATE SIGNED (Month, Day, Year) 7 July 8, 1995					
	PATRICK HU	JOHNS	HOPK			TAL. I	BALTIME	ORF. 1	UD 21205		
	31. DATE FILEO (Month, Day, Yest) 1995	32 AGGISTRAS	S SIGNATURED	delle		1 - 1 - 1					
									DHMH-15 Rev 1/89		

95 20971

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH **HENRY** JULY TURNUPSEED JR. TURNIPSEED JR. 3:18 P 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 52 -40-2543 SEPT. Pages 1, 2, 3 should 9a. FACILITY NAME (if not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 400 BLK.SMALLWOOD STREET NA BALTIMORE CITY RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 10c_CITY, TOWN OR LOCATION 10d. INSIDE CITY a MORE 1 YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? AZN completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit auret NE. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 14. RACE — American Indian Black, White, etc. BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuba 1 YES 2 NO 2 Married IF YES, GIVE WAR OR DATES Specify: BY 3 Widowed 4 Divorced Specify: COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) Denter N A BUNGIN provenent 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, F UCNI TLENE 500 BE notified 19b. MAILINO ADDRESS (Street 2 1037 pe METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION DATE must Burtal 2 Cremation 3 5 Cher (Specify) examiner ERAL SERVICE LICENSEE NAME AND ABDRESS OF FACILITY hours after death. Loralunt Ave. 51512 4300 Wa bas medicai s, or complications that co sed the death. Do not enter the mode of dying, auch es cardiac or respiratory arrest, Interval Betwe cremation, or IMMEDIATE CAUSE (Final Onset and Death the disease or condition Multiple injuries
DUE TO (OR AS A CONTROLENCE OF) resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 prior to burial, traumatic CERTIFICATION attending physician and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 the attent shows any injury, PART ii. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? MEDICAL been signed by the 1 X YES 2 NO OF DEATH? 1 STYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN PHYSICIAN: has be Dept. OR ATTENDING PHYSICIAN: The law S 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) After this certificate death with the State HOSPITAL: OTHER: XXYES 2 NO ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ng Home 5 □ Residence 8 □XOther (Specify) RAILROAD TRACKS 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Dev. Year) 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED marked. 28b. TIME OF INJURY 1 Natural SUBJECT STRUCK BY TRAIN 1 YES 2 NO 7/7/95 BY 1430 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 6 Could not be COMPLETED DIRECTOR: hours after 28 4 Homicide RAILROAD TRACKS 400 Smallwood St. Battimore Cety 29a. CERTIFIER 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. THE FUNERAL (filed within 72 h HOSPITAL 2 X MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: I 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Wonald & Wright MD O.C.M.E. JULY 8,1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 MD WRIGHT 52 REGISTRAN'S SIGNATURE

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, or removal. IMPORTABLY If then 28 its marked or tarm 23 chance and interval or other trainments event interval or other trainments event the medical eventual provides the medical eventual provides the medical eventual provides the medical eventual provides the medical eventual provides the medical eventual provides the medical eventual provides the medical eventual provides the medical eventual provides the medical eventual provides the medical eventual provides the medical eventual provides the medical eventual provides the second eventual provides the medical eventual provides the eventual provides the medical eventual provides the medical eventual provides the medical eventual provides the medical eventual provides the eventual provides the medical eventual provides the medical eventual provides the medical eventual provide
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	FOR STATE REGISTRAR	W 4. 4. 1	STATE OF	MARYLANI	D / DEPAI CERTIF	RTMENT	T OF 1	IEALTH DE AT	AND	MENT/		E		.0572
	1. DECEDENT'S NAME (First	Middle, Last)	Trautf				UF	DEA	ΙП	2. DAT MON JU	REG. NO.	995	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 215-18-546		5. SEX 1 M 2 X F	6. AGE (In yrs	(lest birthday)	IF UNDER	DAYS	IF UNDER	24 HRS. MIN.	7 DAT	E OF BIRTH	21	Countr	PLACE (State or Foreign
OR	90. FACILITY NAME (If not in 2322 Kill					9b. CITY, TOWN OR LOCATION OF GEATN TIMONIUM						9c. COUNTY OF GEATN BALTIMORE		
DIRECTOR	RESIDENCE OF DEC	10b. COUNTY	TIMORE		10c, CI	10c. CITY, TOWN OR LOCATION TIMONIUM								10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	10e. STREET AND NUMBER 2322 Killoran Road					101. ZIP CODE 21093				10g. CITIZEN OF USA				
В	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced 12. WAS DECEDENT EYER IN U.S. AR FORCES? 1 YES 2 F IF YES, GIVE WAR OR DATES					13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No— 14. RACE If yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1 TYES 2 NO Specify: WHIT					American Indien, White, etc.			
COMPLETED	(Specify only highest grade completed) (G Elementary/Secondary (0-12) (College (1-4 or 5 +)					ECCOENT'S USUAL OCCUPATION live kind of work done during most of working b. Do NOT use retired.) Dimemaker				16b. KIND OF BUSINESS/INDUSTRY OWN Home				
BE CO		nd The	lson Fis	her							Middle, Maiden		ndle	
TO E	P. Raymon	l Trau	tfelter			NO ACORESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Killoran Rd., Timonium, MD 21093								
	20a, METHOD OF DISPOSIT 1 (A Buriel 2 □ Crematic 4 □ Denetion 5 □ Other	CEANDDATE Crematory or C	Pari	C			jul	Y Wo	odlav	City or To	ID .			
	21. SIGNATURE OF PUNES	5	10 10	emmo W.	n Fui Pade	ss of fa nera onia	1 Ho Rd.	me of I	Dula ium.	ney V	Valley, Inc.			
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory streat, shock, or heert feither. List only one cause cheach line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):													
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):													
PHYSICIAN: MEDICAL (PART II. Other significa	nt condition	s contributing to	deeth but no	ot resulting	in the un	deriyin	g cauee (given in	Part i. 24e. WAS AN AUTOPSY PERFORMED?		24b.	WERE AUTOPSY FINDINGS AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?	
IAN: N	DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER?				EATH Y] UNC	ERTAI	N D				1 YES 2 NO
HYSIC	1 YES 2 NO 27. MANNER OF OEATN		HOSPITAL: 1 inpetient 2 inpeti	INJURY	28b. TIN		eing Nom 28c. INJ		eldence		ner (Specify) E\$CRIBE HOW II	JURY OC	CUREO	
B	2 Accident 3 Suicide 8	Pending Investigation Could not be determined	28s. PLACE O	OF INJURY — An		M	1 🗌 1	rES 2] NO	28t. LO	LOCATION (Street and Number or Rural Route Number, City or Town, State)			
COMPLETED			CIAN: To the best of a											end menner as stated.
BE	29b. SIGNATURE AND TITLE		29C. LICENSE NUME						E SIGNED	(Month, Day, Year) 6/95 .				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Khim M. Tun., M.D., 1006 Taylor Avenue, Towson, MD 21286														
	JUL 1 2 19		32) REGISTRA	AR'S GRATUR	F	-								

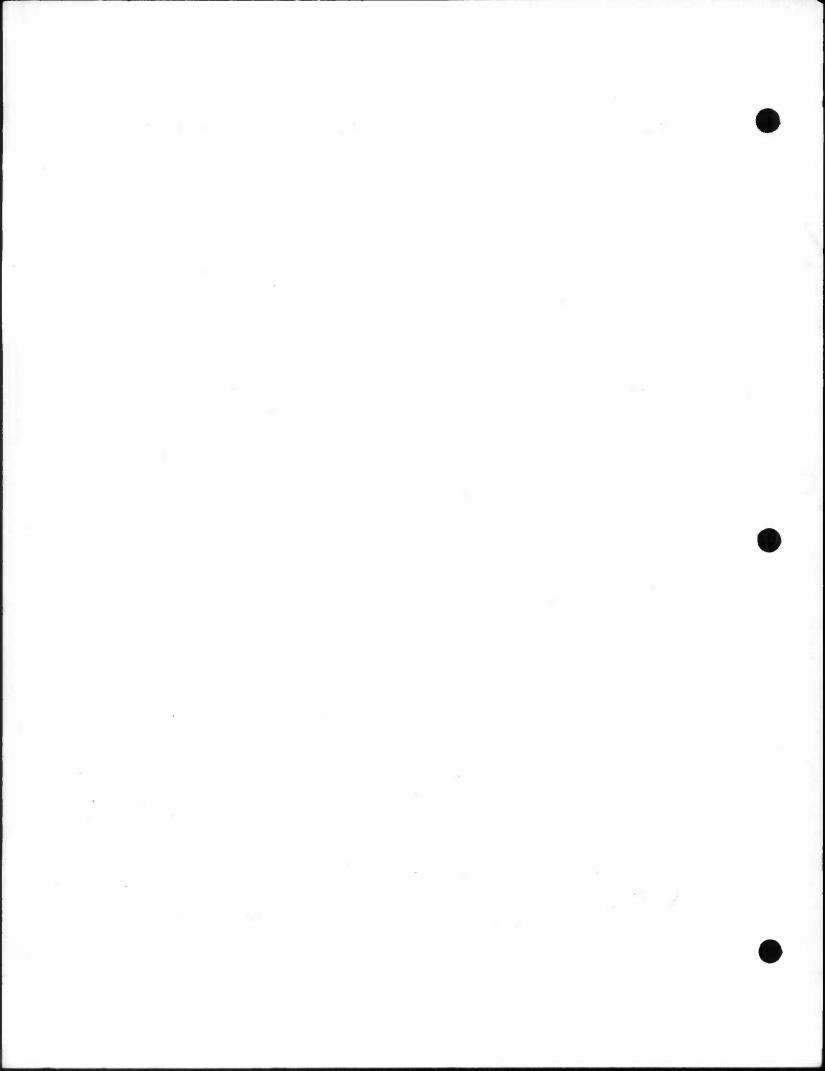


TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIFI	TMENT OF I	REALTH AND MI	ENTAL HYGIEN					
-	1. DECEDENT'S NAME (First, Middle, Last)					DATE OF DEATH		3. TIME OF DEATH			
	Paul	Richard		Titu	ıs	July 04		2145			
	4. SOCIAL SECURITY NUMBER		In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. 7	Month, Day, Year)		INPLACE (State or Foreign			
	363-64-5696	1 X M 2 □ F 40	YRS.			NOV.08,1954 CALIFORNIA					
œ	9a. FACILITY NAME (If not institution, give			96. CITY, TOWN	OR LOCATION OF DEAT	н	9c. COUNTY OF	DEATH			
DIRECTOR	Penisula Reginesidence of Decedent				isbury		Wicomico				
DIRE		COMICO		LLLARDS	TION		10d. INSIDE CITY LIMITS? 1 YES 2 NO				
	10e. STREET AND NUMBER			10	. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?			
ER	RT.1, BOX 16-B -	RICHLAND DRI	VE	2	1874		U.S.A.				
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	U.S. ARMED 2 NO ATES	If yes, sp	ENDENT OF NISPANIC ecity Cuben, Maxican, I 2 NO Specify:	ORIGIN? (Specify Yes Puarto Rican, etc.)	a or No.— 14. RACE — American Indian, Black, White, atc. Specify: WHITE					
8	15. DECEDENT'S EDU (Specify only highest grad	JCATION	16a. DECEDENT'S	JSUAL OCCUPATION	ON	16b. KIND OF BUS	SINESS/INDUSTRY				
E	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	ork done during mo retired.)	st of working			1			
COMPLETED	12TH GRADE		PRESSI	IAN		PRIN	TING				
	17. FATNER'S NAME (First, Middle, Last)					(First, Middle, Maiden					
BE	BRUCE TITUS					IA PARSON	_				
2	19a. INFORMANT'S NAME (Type/Print) MRS. ELIZABETH TITUS 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) RT.1, BOX 16 B - RICHLAND DRIVE - WILLARD										
	20a_METHOD OF DISPOSITION 1	noval from State com	PLACE AND DATE O	F DISPOSITION (Na	me of		CATION — City or 1	Town, State			
	21. SIGNATURE OF SUMERAL SERVICE LI		ONSET UTI	_	ID ADDRESS OF FACIL		INT, MI				
	· Alsen to	1 but	7	HUBBA	RD FUNERA WILKENS A	L HOME, I		MD 21229			
	23. PART I. Enter the diseases, or	complications that coused	the deeth. Do no					Approximete			
	iMMEDIATE CAUSE (Finel disease or condition resulting in death)	e. Contact	CONSEQUENCE OF	Lot	A	ofly	1181	Interval Batween Onset and Death			
ERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events reaulting in death) LAST										
ור כו	PART II. Other aignificent condition	na contributing to death b	ut not resulting in	the underlying	ceuse given in Pa	rt I. 24a. WAS AN	AUTOPSY 24	b. WERE AUTOPSY FINDINGS			
S						PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
						1 YES 2	_ NO	OF DEATH? 1 VES 2 □ NO			
ä	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YES	ON D	UNCERTAIN			N. 23 1 0 110			
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH								
YSI	1X YES 2 □ NO	HOSPITAL: t ☐ inpatient 2 X ER/Outp		OTHER: 4 Nursing Nom	e 5 ☐ Residence 6 ☐	Other (Specify)					
Y PHYSICIAN: MEDIC	27. MANNER OF DEATH 1 Natural 5 Pending Investigation	Month Car (Mail)	206. TIME 210	OF 25c. MJ RY WO	RK7	Sh = A	SURV OCCURED	self			
ED BY	2 Accident Investigation 2 Splicide 6 Could not be determined	28e. PLACE OF INJURY building, etc. /Spec	— At home, ferm, at	reet, factory, office	21	H. LOCATION (Street a City or Styrn, Stage)	nd Number or Famil	Apute Number			
			14011	t		P500 K	iltan	& Are			
COMPLETED	CERTIFYING PNYS	ICIAN: To the best of my knowledge. On the basis of examination	edge, death occurred and/or investigation	at the time, data , in my opinion, d	and place, and due to i	the cause(a) and man e, date and place, and	ner sa stated. d due to the cause	a) and manner as stated.			
BEC	299 SIGNATURE AND TITLE OF CERTIFIE		44.0		29c. LICENSE NUMBE			D (Month, Day, Year)			
	30 MARIE AND AND SESSON WA	IO COMPLETED CAUSE OF DEA	ATN (ITEM 27) (Type I	Print)	O.C.M.	E.	July	05 1995			
	31. DATE FILED (MONT) 1995 Ju	KE MD	111 P		reet, Ba	ltimore	, Mary	land 21201			



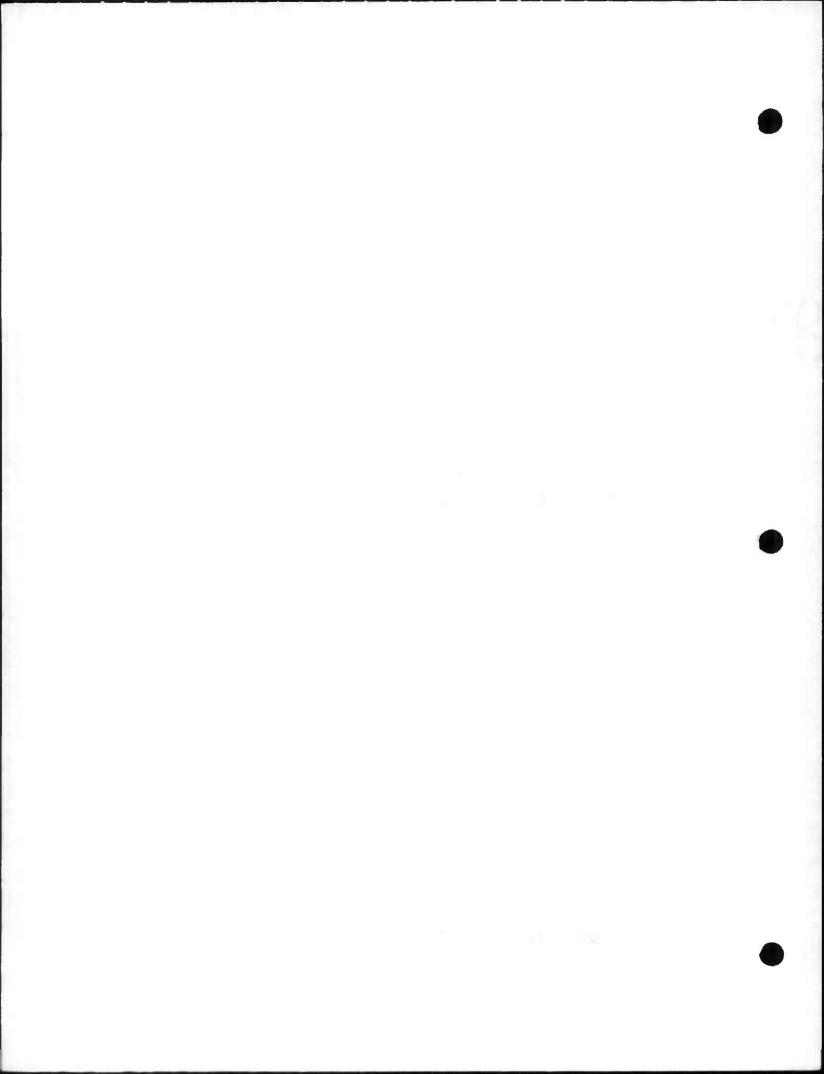
1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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DIVISION OF	

	1. DECEDENT'S NAME (First, Middle, Last)	7					2. DATE	OF OEATH	AY	YEAR	3. TIME OF DEATH		
	EVA	TAYLOR						7 0		6	8:50 PM		
	4. SOCIAL SECURITY NUMBER	The second secon	(In yrs. les	MOI	UNDER 1 YEA			OF BIRTH h, Day, Year)		8. BIRTHP Country	LACE (State or Foreign		
	232-62-1854		71	YRS.			1-1	6-192	2.4	W.	Virginia		
	9a. FACILITY NAME (If not institution, give s					N OR LOCATION OF				TY OF DE	ATH		
	University of M	laryland H	osp.		Ва.	timore	City		N/	A			
	10a. STATE 10b. COUNTY	1		19c. CITY, TO	OWN OR LO	CATION	10d. INSIDE CIT LIMITS?				10d. INSIDE CITY		
	Md. N/	<u>' A</u>		Ba1	timo	re					1 X YES 2 NO		
ייייייייייייייייייייייייייייייייייייייי	10e. STREET AND NUMBER	3 0				10f. ZIP CODE					HAT COUNTRY?		
	510 W. Redwoo					21201				J.S.			
	1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	2 X X		If yee,	specify Cuban, Mex	exican, Puarto Rican, etc.)			Black,	- American Indian, White, alc.		
	3 🔀 Widowed 4 🗌 Divorced	W YES, GIVE HAR ON	DATES		''''	'ES 2 X NO Spe				Whi			
	15. DECEDENT'S EDUC (Specify only highest grade			CEDENT'S USU		ATION most of working	168	. KIND OF BU	SINESS/IND	USTRY			
	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ho.	Do NOT use rel	tired.)		İ	/ /					
	8 17. FATHER'S NAME (First, Middle, Last)	N/A	Ho	usewi	.ie			N/A					
		kins				18. MOTHER'S							
	19a. INFORMANT'S NAME (Type/Print)	KIIIS	191	MAILING ADI	DESS /Stree	Mam		Reyno		Code			
	Cora Taylor					n Stree					224		
ł	20a. METHOD OF DISPOSITION	20	b. PLACE	NDDATEOFD	SPOSITION	(Name of	DAT		CATION				
20s. METHOD OF DISPOSITION 1 XB Burlei 2 Cremetion 3 Removal from State 4 Donation 5 Dother (Specify)										re.	Md.		
1	Baltimore, Md. 21. SIGNATURE OF FUNERAL RESPICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 21.231												
1	Profes	es selle	20		Lill	y & Zeil	er In	c. 190	21 1 Eas	.Z3I stern	Ave.		
	23. PART I. Enter the diseases, or o	complications that cause	d the de	ath. Do not a							Approximata		
	shock, or heart fallure. I IMMEDIATE CAUSE (Finel	List only one cause on	sech live	•							Interval Between Onset and Death		
	disease or condition resulting in death)	0	S	TPSI	S						1 48		
ı		DUE TO (OR AS			^								
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING METABOLIC ACIDOSIS OUE TO (OR AS A CONSEQUENCE OF): MULTIPLE PULMBNARY EMBULSM										24			
if any, leading to immediate cause. Enter UNDERLYING										24			
۱	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS	A CONSEC	DUENCE OF):	, 0011	UN DIEL V	(-1130	C12 1-1					
	resulting in death) LAST												
	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS												
								PERFOR	MED?	1	WAILABLE PRIOR TO		
							_	1 TYES 2	Ø NO		OF DEATH?		
	DID TOBACCO USE CONTR	RIBUTE TO CAUSE O	OF DEA	TH YES		UNCERTA					YES 2 NO		
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			E OF DEATH (C	heck only o								
PHTSICIAN	1 TYES 2 NO	FIOSPITAL:	patient 3		HER: Nursing H	ome 5 - Rasidenc	e 6 🗆 Othe	r (Specify)					
Ì	27. MANNER OF DEATH 1 Natural 5 Pending	25a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY	28c.	NJURY AT WORK?	28d. DES	CRIBE HOW I	NJURY OCC	URED			
	2 Accident Investigation	50 51 455 55 1111				YES 2 NO							
1	3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJUR building, etc. (Spe	Y At ho	no, farm, stree!	t, factory, o	fica	28f. LOC City	ATION (Street in or Town, State)	and Number	or Rural Rol	ute Number,		
	29a. CERTIFIER			_	_								
	(Check only CERTIFYING PHYSIC	CIAN: To the best of my know											
		R: On the beals of axamination	on and/or i	nvestigation, in	my opinior	, death occured at)	he lime, data	and place, an	d due to the	cause(a)	and manner as stated.		
	29b. SIGNATURE AND TITLE OF CERTIFIER	· Se h	1	M)		A L LA			-	SIGNED (A	Wonth, Day, Year)		
ŀ	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF D	FATH (ITES	1 27) /Xuna Drin	2)	AU417	167371	417 703 +) + 1	00/95		
	University of M.	aryland,		29 5		leene	CF	B	16.	4			
	31. DATE FILED (Month, Day, Year)	32) TESISTEMENT VA				ا حداد	26.	, 100	(11/2)	000			
	JUL 1 2 1995 /#	War and a second											
1	0022												

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

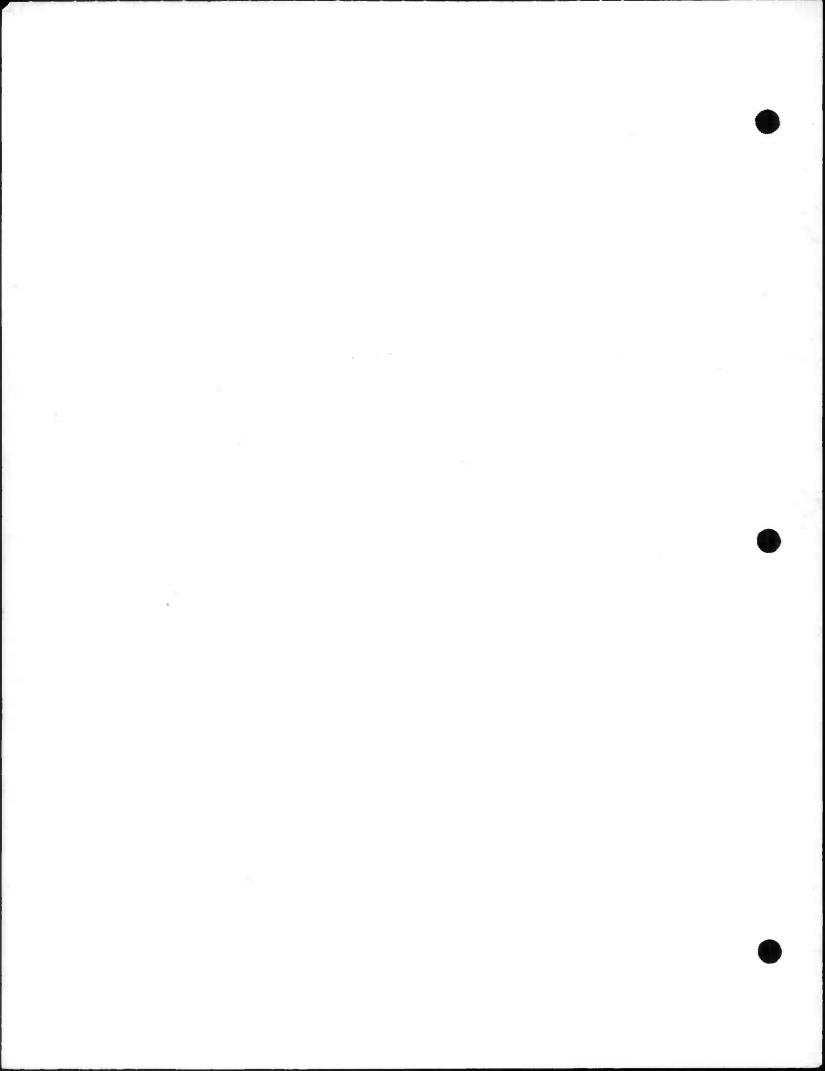


ysician. irial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

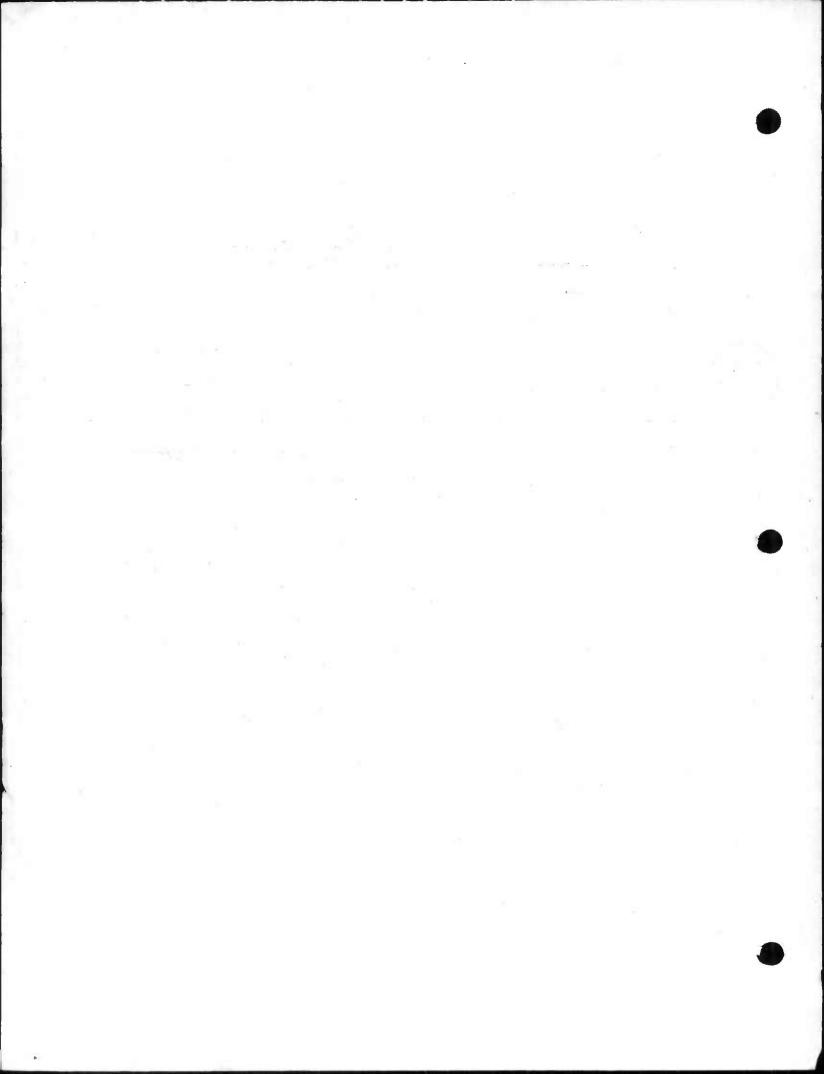
DIVISION OF VITAL RECORDS, P.O. BOX 68760

E	P		
ing	the		
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death, Page 6 may be retained by the hospital or attending phy	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buil		
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2	101	De fi	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
		_	_

	1 - FOR STATE REGISTRAR	STATE OF MARYLANI	D / DEPARTA	MENT OF H	EALTH AND I	MENTAL HYGIEN	E				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH			
	FRANK	URSPRU	CH			JULY 10), 1995	3:45 A. M			
	The state of the s			UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	a BIRT	THPLACE (State or Foreign			
	219-03-6772 9e. FACILITY NAME (If not institution, give stree	1 K M 2 🗆 F 74	YRS.			DEC. 28, 1920		TTO.,MD			
OR	504 SUNSET ROAD	and number)	96		OR LOCATION OF DE	ATH	BALTI	BALTIMORE CITY			
딦	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		400 CITY Y	OWN OR LOCAT	TION						
DIRECTOR		IMORE CITY	100.011,1		LTIMORE			10d. INSIDE CITY LIMITS? 1 X YES 2 NO			
AL	10e. STREET AND NUMBER			101	. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?			
FUNERAL	504 SUNSET ROAD				21223		U.S	.A.			
5	11. MARITAL STATUS 1 1 Never Merried 2 Merried	2. WAS DECEDENT EVER IN U.S. FORCES? 1 V YES 2				IC ORIGIN? (Specify Yee , Puerto Rican, etc.)		CE — American Indian, ck, White, etc.			
ВУ	3 X Widowed 4 □ Divorced	IF YES, GIVE WAR OR DATES			2 XNO Specify			odfy:			
	15. DECEDENT'S EDUCA	TION 18a	. DECEDENT'S US	UAL OCCUPATION	ON .	16b. KIND OF BUS	INFSS/INDUSTRY	WHITE			
	(Specify only highest grade co	mpleted) College (1-4 or 5+)	(Give kind of work life. Do NOT use re	done during mo- tired.)	st of working						
APL	7TH GRADE		VAREHOUS	EMAN		RETA	IL GROCE	RY			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maiden					
BE	LOUIS URSPRUCH					NE SCHAEFF					
2	190. INFORMANT'S NAME (Type/Print) CANDICE URSPRUCH					oute Number, City or Town		100 00010			
	20s. METHOD OF DISPOSITION					2 - SILVER					
	1 N Buriel 2 Cremation 3 Remove 4 Donation 5 Other (Specify)		CE AND DATE OF D			1 .	CATION — City or 1 LTIMORE	fown, State			
	21. SIGNATURE OF FUNERAL SERVICE CEN	BEED 11		22. NAME AN	ID ADDRESS OF FAC	CILITY	7.0				
	· M. Tleas	Cetera	\sim			AL HOME, IN		MD 21229			
	23. PART I. Enter the diseasea, or con-	nplications that caused the	deeth. Do not					Approximate			
	ahock, or heert failure. Lis IMMEDIATE CAUSE (Fine)	st only one cause on each	line.			,	-2-14	Interval Between Onset and Death			
	disease or condition resulting in death)	Conges	twe	Lea	it fo	rilure		THE BLA			
	DUE TO (OR M A CONSEQUENCE OF):										
NOI	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):										
CAT	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DO	roet	e				90 mg			
THE	thet initiated events resulting in death) LAST	DUE TO (OR AS A CON	ISEOUENCE OF):					a g			
CERTIFICATION	d.										
- 1	PART II. Other significant conditions of	contributing to deeth but no	ot resulting in t	he underlying	ceuse given in l			b. WERE AUTOPSY FINDINGS			
EDICAL						PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
ME						_ _ ′		1 TES 2 NO			
N.	DID TOBACCO USE CONTRIE				UNCERTAIN						
PHYSICIAN:		OSPITAL:		THER:	_/						
HYS	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME O		5 € Residence 1	28d. DESCRIBE HOW IN	I II IPV OCCUPED				
	1 Netural 5 Pending	(Month, Day, Year)	INJURY	WO	RK?	200. DESCRIBE NOW IN	JOHT OCCORED				
D BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY — At building, etc. (Specify)	t home, ferm, stree	it, factory, office		28f. LOCATION (Street et	nd Number or Rural	Route Number,			
E	4 Homicide determined	bulloning, etc. (Specify)				City or Town, State)					
COMPLETED	29e. CERTIFIER (Check only	N: To the best of my knowledge,	, death occurred a	t the time, date	end place, end due (to the cause(e) end men	ner as stated.				
Š	one) 2 MEDICAL EXAMINER:	On the basis of examination end	/or investigation, in	n my opinion, de	eath occured at the t	lme, date end place, end	due to the ceuse	(e) end manner ee stated.			
шШ	29b. SIGNATURE AND TITLE OF CERTIFIER	/			29c. LICENSE NUM	BER	29d. DATE BIGNE	D (Month, Day, Year)			
TO B		pricen	74.	<i>D</i>	026	307	>7/10	195			
	DR. RANI S. KARII				D - BALT	IMORE MPD	21227 ICAL BUT	LDING			
	31. DATE FILED (Month, Day, Year)	22. REGISTRAR'S GIGNATUR	E		2 21						



		1 - FOR STATE REGISTRAR	STATE OF MARYLAN		TMENT OF H		MENTAL HYGIE REG. NO					
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH			
			ladis		√i11iam	ıs	July	06,1995	3:50 P			
Pl		10- ~ / - /	10 M 2 8 F 67	rs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Dey, Year) 3-4-192	Co	ATHPLACE (State or Foreign untry)			
. 2, 3 should	стов	90. FACILITY NAME (If not institution, give str MARY LAND GE RESIDENCE OF DECEDENT		iTAL		TY, TOWN OR LOCATION OF DEATH BALT 9c. COUNTY OF DEATH N/A						
L. Pages 1.	DIREC	10e. STATE 10b. COUNTY	HA		Y, TOWN OR LOCAT	TION			10d. INSIDE CITY LIMITS? 1 YES 2 NO			
nsit permit.	ERAL	100 STREET AND NUMBER 3234 BELAIR	Pb.			21217		10g. CITIZEN O	F WHAT COUNTRY?			
215-0020 attending physician. se as the burial-transit	BY FUNER	11. MARITAL STATUS 1 Newer Merried 2 Married. 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	MO	If yee, sp	ENDENT OF HISPAI ecity Cuban, Mexico 2 NO Specifi	an, Puerto Rican, etc.)	RIGIN? (Specify Yee or No— 14. RACE — Amer Black, White, Specify: BL.				
or attend	FTED	ts. OECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION 184 completed) College (1-4 or 5 +)	(Give kind of w life. Do NOT us		ON st of working		166. KIND OF BUSINESS/INDUSTRY DOMESTIC WORK				
E STATE	黑	17. FATHER'S NAME (First, Middle, Last)	NH	446	PORER				301215			
		BILL SALLE	<i>y</i>			ELLEI	AME (First, Middle, Maide COR	LEY				
ay be man	000	190. INFORMANT'S NAME (Type/Print) / EVA DA VIS		3234		nd Number or Rural		BALT.				
aust de la		20e. METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Remo 4 Donetion 5 Other (Specify)	val from State cemeter	v. cremetory or of	of DISPOSITION (Na ther place)		7/	ocation — GI	en Burnie			
		21. SIGNATURE OF FUNERAL SERVICE LICE	NISEB /	CAL	22. NAME AN	CEM ID ADDRESS OF FA	CILITY NERAL H	וטפ ייאן	CNIE			
BALIIN er death. Pag the funeral di mal.		Hulle	VIImal	Tel			LINE ST		B 3/2/2			
od with the modical convolution of the modical control of the modical control of the modical control of the modical of the modical of the modical of the modical of the modical of the modical of the modical of the modical of the modical of the modical of the modical of the modical of the modical of the modical of the modical of the modical of the modical of the modical of the the modical of the the the the the the the the the the		IMMEDIATE CAUSE (Fine)	End Stage DUE TO (OR AS A CO)	AIDS		de of dying, auc	h aa cardiec or res	piratory errest,	Approximate Interval Between Onset and Death UNKNOWN			
th certificate be execute ending physician and coll Hygiene prior to burian or other traumatic	CERTIFICATION	Sequentially list conditions, if arry, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in daeth) LAST b. OUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF):										
2 9 8 3	7	PART ii. Other significent conditions	contributing to death but r	not resulting in	n the underlying	ceuse given in	Part i. 24e. WAS A	N AUTOPSY 2	4b. WERE AUTOPSY FINDINGS			
requires that the een signed by the of Health and N	MEDIC/						1 TYES		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
AL RE he law requ has been b Dept. of I n 23 sho	N.	DID TOBACCO USE CONTR				UNCERTAIL	N.K					
N: The icate his State C	SICIAN:		26. PLACE OF OEATH (Check only one) HOSPITAL: OTHER:									
VS PHYSICIAN: The law requires that ter this certificate has been signed lash with the State Detr. of Health a marked, or item 23 shows any	표	27. MANNER OF DEATH 1 X Netural 5 Pending	1 Inpetient 2 KER/Outpetier 28e. DATE OF INJURY (Month, Dey, Year)	28b. TIME	E OF 26c. INJI		6 Cher (Specify) 28d. DESCRIBE HOW	INJURY OCCURED				
TTENDII TTENDII atter de 28 Is	TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — A building, etc. (Specify)	At home, term, st			26t. LOCATION (Street City or Town, State	and Number or Rura	al Route Number,			
AL DIRE	COMPLET	29e. CERTIFIER (Check only one) 1 (CHECK ONLY ONE) 2 MEDICAL EXAMINER	IAN: To the best of my knowledge: On the basis of examination end	e, death occurre	d at the time, date	end place, end dua	to the cause(e) end me	enner se stated.	e(s) and manner es stated.			
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If	BE	296. SIGNATURE AND TITLE OF CERTIFIER	mer			29c. LICENSE NUM		29d. DATE SIGN	ED (Month, Day, Year) 1y 6,1995			
· (x	2	30. MAME AND ADORESS OF PERSON WHO Stella Thalha	amer, M.D.	c/o Ma	ryland	Genera	al Mospit	al				
V		31. DATE FILED (Month, Doy, Year) JUL 1 2 1995	32. HEGISTHAMS SIGNATUR	Rardall								



Item9a,g-725,7-12-95,perf.h.,dk

		1 - STATE REGISTRAR	STATE OF MARYL		RTMENT OF H		MENTAL HYGIEN				
		1. DECEDENT'S NAME (First, Middle, Last KATHY		STLEMAN			2. DATE OF DEATH MONTH		EAR	ME OF DEAT	тн Д м
Pie		4. SOCIAL SECURITY NUMBER 219-62-0186		(In yrs. lest birthday) 40 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) SEPT. 11,	8.	BIRTHPLACI Country	E (State or Fo	reign
, 3 should	СТОВ	90. FACILITY NAME Wilkens 2022 WILKINS	AVENUE			MORE CI	ATH	9c. COUNTY			
s 1, 2,	5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUN	TV	Live Av				14			
permit. Pages	- DIRE	Md . N//			Y, TOWN OR LOCA ltimore				1 00	INSIDE CITY LIMITS? YES 2	
- TS	VERAL	410 S. Pulaski	St.	·	10	21223		10g. CITIZEN	USA	COUNTRY?	
215-0020 attending physician. se as the burial-transit	BY FUNE	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 (NO	If yes, sp	CENDENT OF HISPAN Hecify Cuban, Mexican 5 2 NO Specify.		8 or No — 14.	RACE — Ar Black, White Specify:		ite
r atter use a	ETED	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12)	OUCATION de completed) College (1-4 or 5+)	16a. DECEDENT'S (Give kind of ville. Do NOT us	USUAL OCCUPATION work done during mose retired.)	ON ost of working	18b, KIND OF BU	SINESS/INDUS	TRY		
CIL.	COMPL	7	N/A	Meat	Cutter		Food I	ndustr	٧		
SORE	8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAM	AE (First, Middle, Maider				
	BE	Marshal Whist 190. INFORMANT'S NAME (Type/Print)	tleman			Verna	Tingle				
M P C III	TO	Karen M. Hild					oute Number, City or Tov			21	117
A Person		28e. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Rei	206	PLACE AND DATE	OF DISPOSITION (Na	ame of		CATION - City			11/
Page 6 married director, page 10 must		4 Donation 5 Other (Specify)	Ir	ne Green				ltimor	e, Md		
AL I III death. Pay tuneral di di di di di di di di di di di di di d		21, SIGNATURE OF FUNERAL SERVICE L	JCENSEE A		Gary L	ND ADDRESS OF FAC	Tuneral	Home o	f Elk	In	C.
EAL. ter death the fune oval. ai exam		Lary	d. Loup	nan	5695 M	ain St.,	Elkridge,	Md.	21227	,	
withing hours after death. Puge ripletely filled in by the funeral dim cremation, or removal.		IMMEDIATE CAUSE (Final disease or condition	a. A.I.D.S	I the death, Do nech line.	not enter the mo	de of dying, auch	as cardiac or reap	iratory arreat	2	Approxima Interval Be Onset and	etween
		reaulting in death)		CONSEQUENCE OF	F):						
OX 687.0 be executed sician and corridor to burial, traumatic ex	RTIFICATION	Sequentially list conditions, if any, leading to immediate	b. DUE TO (OR AS A	CONSEQUENCE OF	F):						
cate be thysician a prior trau	CA	cause. Enter UNDERLYING CAUSE (Disease or injury	c								
eath certificate attending physical trail Hygiene pr	FF	that initieted eventa reaulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	F):						
the death y the attend Mental H	빙	DART II Other classificant and dist	d.								
a a d a	EDICAL	PART II. Other algnificant condition	ma contributing to deeth be	ut not resulting i	in the underlying	g ceuse given in i	PERFO	RMED?	COMP OF DE		TO
St. of Deen	N: M	DID TOBACCO USE CON	TRIBUTE TO CAUSE O	F DEATH YE	S NO	UNCERTAIN		ECTION	וםי	YES 2 N	10
B B B B	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	TH (Check only one) OTHER;						
Certificate the State	IXSI	XX YES 2 NO	1 ☐ Inpatient 2 ☐ ER/Outp		4 - Nursing Hom	e 5 X Residence I					
F state	ву РНУ	Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. TIMI	URY WO	PRK?	28d, DESCRIBE HOW	NJURY OCCUR	ED		
TTENDI CTOR: A after da	ETED E	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, term, s	street, factory, offic	•	281. LOCATION (Street City or Town, State)	end Number or F	Rural Route N	umber,	
Z Z Z Z	COMPL	2XXMEDICAL EXAMIN	SICIAN: To the best of my knowl						euse(s) end r	manner ee st	inted.
TO THE HOSPIT TO THE FUNER De filed within	TO BE	29b SI HATURE AND TITLE OF CENTER	orlewy			O.C.M.		≥ JUI		n, Day, Year) L, 199	5
	1	J. Laron Locke				et, Bali	timore,	Maryla	and 2	21201	
		31. DATE FILED (Month, Day, You) 19									

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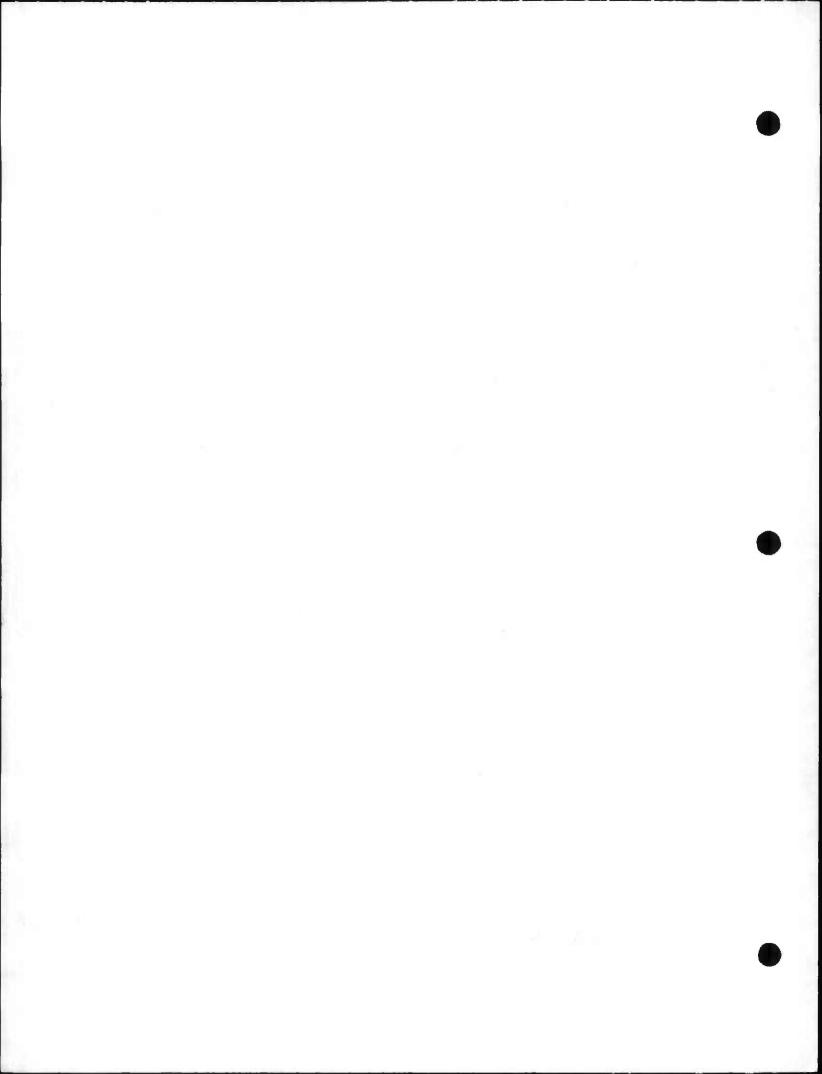
DIVISION OF VITAL RECORDS, P.O. BOX 68760

y the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should notal. cal examiner must be notified at once. TO BE COMDIETED BY FINEDAL DIDERTOR	TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. TO BE COMPLETED BY DHYSICIAN: MEDICAL CERTIFICATION
VSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. S certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. In the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. In the State Dept. of Health and Mental Hygiene prior to burial, the medical examiner must be notified at once.	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transible filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

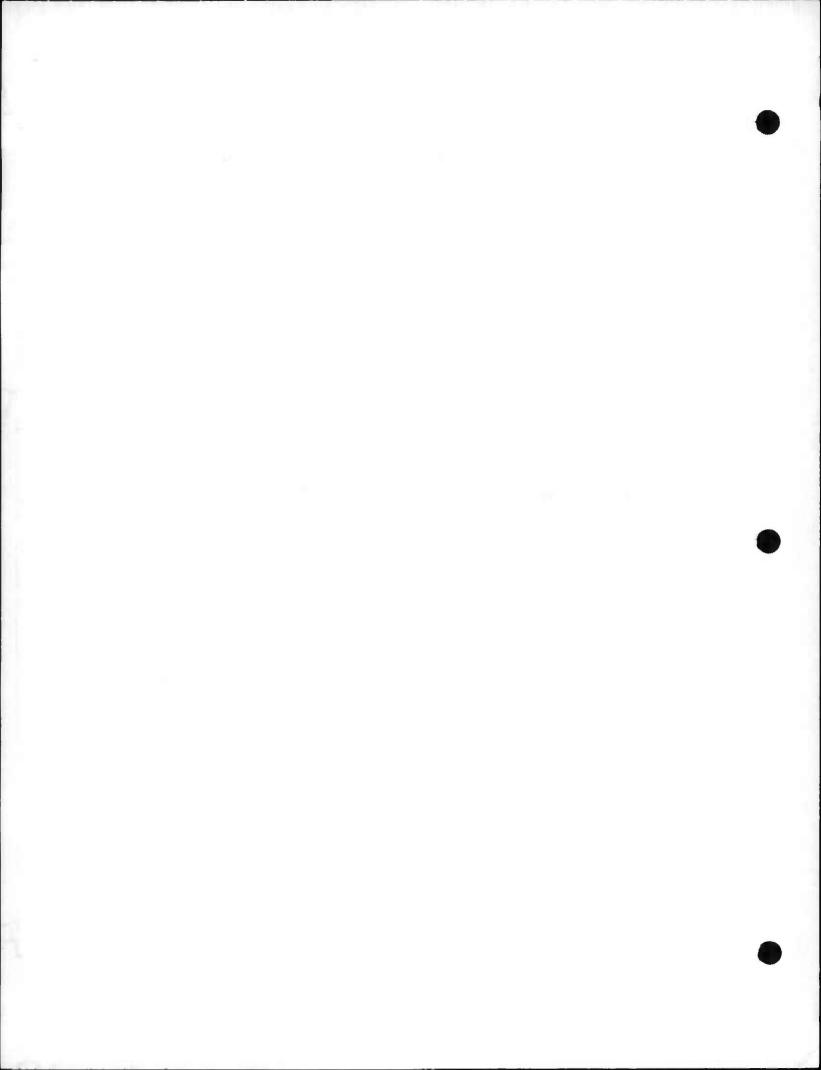
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.

_	REGISTRAR				CERTIF	ICAL	E OF	DEATH		REG. NO				
	1. DECEDENT'S NAME (First, INELL	Middle, Last)		Į.	WOLFE				2. DATE C	F DEATH	AY .	YEAR	3. TIME OF C	DEATH M
	4. SOCIAL SECURITY NUMB	En	5. SEX									95	1.	17-11
	214-50-973		1 M 2 X F	5. AGE (In yr.	s. lest birthday) YRS.	IF UNDER	DAYS	IF UNDER 24 HRS, HOURS MIN.	7. DATE 0 (Month,	F BIRTH Day: Year) 09 —1 9:	36	Countr	IPLACE (State of	or Foreign
	90. FACILITY NAME (# not in:				-	9h CITY	TOWN	OR LOCATION OF DE		ノンーエン、		TETATA		
Œ	ANNE ARUND			TER				OLIS	CAIN					
DIRECTOR	RESIDENCE OF DEC		TOTAL OLAN				12 12 12				AIN	NE AR	UNDEL	
E I	10e. STATE	10b. COUNTY	,		10c. CI1	Y, TOWN (OR LOCA	TION					10d. INSIDE C	YTE
	MARYLAND	ANNE	ARUNDEL			GI	EN I	BURNIE					1 YES	NO NO
FUNERAL	10e. STREET AND NUMBER						10	. ZIP CODE			10g. CIT		VHAT COUNTRY	Y7
ij.	1609 LORIMER	ROAD						21061				U.S	.A.	
5	11. MARITAL STATUS 1 Never Married 2	Mandad	12. WAS DECEDENT FORCES? 1	T EVER IN U.S	S. ARMED			ENDENT OF HISPAN ecify Cuban, Mexica			or No-	14. RACE	- American I	indien,
B	3 Widowed 4XXDIvo		FORCES? 1 IF YES, GIVE W	AR OR DATES	VX.			NO Specify		, , , , ,		Speci		E
COMPLETED	15. DECI (Specify only	EDENT'S EDUC	CATION completed)	164	DECEDENT'S	USUAL O	CCUPATIO	ON ost of working	18b.	IND OF BU	SINESS/IN	DUSTRY		
9	Elementary/Secondary (0		College (1-4 or 5+)	ille. Do NOT u	se retired.)	ourng me	or worlding	ı					
₩ P	88		N/A		HOME	MAKEF	ξ			O	NN HO	OME		
8	17. FATHER'S NAME (First, MI	ddle, Last)	601	_				16. MOTHER'S NA	ME (First, Mi	ddle, Meiden			,	
BE	ROBERT		SEA	لل			_	OLLIE				VESAY		
2	190. INFORMANT'S NAME (7) CLYDE	rpe/Print) WOLE	PE:					ROAD, GLI				(c Code) 210	060	
	20e. METHOD OF DISPOSITI	ON n 3 🗆 Remo	oval from State	cameter	ACE AND DATE	ther place!			7/12			- City or To		
	21. SIGNATURE OF FUNERAL			GLE	N HAVE			AL PARK	1995	GLE	N BUI	RNIE,	MD.	
	·XI	0-0	CHIER			1	SEC	OND AVEN	UE, S	.W.		FUNE	CRAL HO	ME
\neg	23. PARFT. Enter the di	sesses, or c	ontplications the	ceused the	deeth. Do	not enter	the mo	BURNTE, I	MARYT. h ss cerdi	AND 2	ratory ar	rrest.	Approx	timate
	shock, or he	art fellure. I	Liat only one cau	se on each	line.						,		Interva	Batween
	disease or condition	<u>.</u>	-	hu	IMM	10							Ollowit	and Destil
	resulting in death)		DUE TO	OR AS A CO	NSEQUENCE O	F):		٨	• .				-	
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CERTIFICATION	Sequentially list conditi if any, lesding to immed		DUE TO	OR AS A CO	NSEQUENCE O	Ð: 1		`	1		1		1	
S	cause. Enter UNDERLYI CAUSE (Disease or Inju		Ug	Dav	19-	17	u	ers.	e m	100 l	usi	m		
H	that initiated events resulting in death) LAS	· .	DUE TO	ON AS A CO	NSEQUENCE O	F):	1	orl di	04.4	-0				
Ä	resulting in death) CAS		- CN	DS	1 Beg		in	ou cu	SOTY	SC.				
	PART II. Other significe	nt condition	s contributing to	deeth but n	ot resulting	In the un	derlyin	g ceuse given in	Part I.	4s. WAS AN		24b.	WERE AUTOPS	Y FINDINGS
EDICAL										PERFOR			AMAILABLE PRI	OR TO
									- 1	TES 2			OF DEATH?	7.00
Σ.	DID TOBACCO U	SE CONTE	RIBUTE TO CA	USE OF D	PATH Y	S \square I	VO TR	UNCERTAIN	ı 🗆				1 WES 2	
N N	25. WAS CASE REFERRED TO	-			PLACE OF DEA			OTTERITAL	101					
Sic	EXAMINER?		HOSPITAL:	ER/Outpatier	nt 3 □ DOA	OTHER 4 Num		a 5 🗆 Residence	8 COther	Snacifu)	-			
PHYSICIAN:	27. MANNER OF DEATH		28e. DATE OF	INJURY	28b. TIN	E OF	28c. INJ	URY AT		RIBE HOW II	NJURY OC	CURED		
ВУ Р		Pending nvestigation	(Month, De	ly, Year)	IN.	M		YES 2 NO						120
	a - a	Could not be	28e. PLACE Of	F INJURY — A	Al home, farm,	street, lect	ory, offic		28f. LOCAT	ION (Street o	nd Numbe	r or Rural R	loute Number,	
COMPLETED	4 Homicide	letermined		etc. (upocity)					City or	Town, State)				
7	29e. CERTIFIER (Check only	IFYING PHYSIC	CIAN: To the best of	my knowledge	e, death occurr	ed at the t	ime, date	end place, end due	to the caus	(s) end man	ner as sta	rted.		
OM			R: On the beels of ex										end manner e	s stated,
U C	296. SIGNATURE AND TITLE	OF CERTIFIER						29c. LICENSE NUN	(BER		29d. DAT	TE SIGNED	(Month, Day, Ye	oar)_
0	Auge (Son	nou	SV	w	>		DO	831	4	•	7/1	0/00	
임	30 NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF DEATH	(ITEM 27) (Type	Print)		\ \ \ \ \ \	^		Λ			
	THOMOGE	()A	man An	15	MO	De	15	Eiderel	m 6	W 1	Jw.	MON	alnyh	D-140/
	St. DATE FILED (Month, Day	os de	A STATE CHE PA	S. S. S. S. A.	t.			U	1			- 10		- 1
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ex hours after thanh. Page 6 may be retained by	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in its the terms director, page 5 should be	rema
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		FOR	STATE OF MADY	LAND / DES	DTMFNT 1	NE 11541511 4415			
		1 - STATE REGISTRAR	STATE OF MARY	CERTI	FICATE	JF HEALIH AND OF DEATH		GIENE B. NO.	
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DE	ATH	3. TIME OF DEATH
		William Joh		r			July	10, 199	6:20 A.M
			5. SEX 6. AGE	(In yrs. last birthda 44 YRS	MONTHS C	EAR IF UNDER 24 HRS. AYS HOURS MIN.	7. DATE OF BIR (Month, Day,) Jan. 10,	(nar)	. BIRTHPLACE (State or Foreign Country) Maryland
	_	Se. FACILITY NAME (If not Institution, give street			9b. CITY, TO	OWN OR LOCATION OF	DEATH	9c. COUNT	Y OF DEATH
	5	Manor Care Nursing	Center			Towson		Ba	ltimore
	DIRECTOR	10a. STATE 10b. COUNTY		10c. (TTY, TOWN OR	LOCATION			10d. INSIDE CITY
		Maryland Bal	timore			D	undalk		1 TES 2 NO
	3AL	10a. STREET AND NUMBER				101, ZIP CODE		10g. CITIZE	EN OF WHAT COUNTRY?
	FUNERAL	2112 Willow Sprin					222		ed States
		11. MARITAL STATUS 1 X Never Married 2 Merried	12. WAS DECEDENT EVER FORCES? 1 YES	2 X NO	13. WAS	S DECENDENT OF HISPA es, specify Cuban, Mexic	ANIC ORIGIN? (Specian, Puerto Rican, a	Ify Yes or No— 1-	4. RACE — American Indian, Black, White, atc.
	BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR I	DATES	1 -	YES 2 X NO Spec	city:		Specify: White
	9	15. DECEDENT'S EDUCA (Specify only highest grade co		(Give kind o	'S USUAL OCCU	JPATION ng most of working	16b. KIND (OF BUSINESS/INDU	STRY
	LET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT	use retired.)		Man	reland Ct	ata Carraman
once.	COMPL	17. FATHER'S NAME (First, Middle, Lest)		Fres	s Opera		IMAL IMAL Middle A		ate Governmen
7	U U	George Edward	Yeager			Marga	,,,		Ellinghaus
notified	00	19a. INFORMANT'S NAME (Type/Print)		19b. MAILI	NG ADDRESS (S	treet and Number or Rura			-
Pe	2	Debra Jordan		509	E. Jop	oa Rd., Ba	ltimore,	MD 21	286
must b		20e. METHOD OF DISPOSITION 1 XBuriel 2 Cremetton 3 Remove		b. PLACE AND DAT		ON (Name of	DATE 2	Oc. LOCATION — CI	ty or Town, State
		4 Donetion 6 Other (Specify)		Mt. Zio	n Ceme	tery 7/1	2/95	Baltim	ore, MD
examiner		21. SIGNATURE OF FUNERICE STRICK	. •						
No.	\Box	Sugar of of	mann		87	17 Green P	astures	Dr., Bal	timore,MD 2128
cremation, or removal		23. PART I. Ental the diseases, or conshock, or heart fellure. Lit IMMEDIATE CAUSE (Final disease or condition	at only one ceuse on	ed the deeth. Do eech line.	o not enter th	e mode of dying, au	ch as cerdisc or	respiratory arres	Approximate Interval Between Onset and Daath
rent,		resulting in death)	DUE TO (DR AS	A CONSEDUENCE	DF):	· · · · · · · · · · · · · · · · · · ·			54
u Hygiene prior to burial, or other traumatic er	ERTIFICATION		DUE TO (OR AS	A CONSEDUENCE A CONSEDUENCE	OF):				Sy
ntal Hygiene prior to burial, y, or other traumatic e	AL CERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS	A CONSEDUENCE	OF):	riying cause given is		RS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
th and Mental Hygiene prior to burial, any injury, or other traumatic e	· .	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEDUENCE	OF):	rlylng cause given in	P	ERFORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
th and Mental Hygiene prior to burial, any injury, or other traumatic er	MEDICAL CERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions	DUE TO (OR AS	A CONSEDUENCE A CONSEDUENCE but not resulting	OF): OF):		P		24b. WERE AUTOPSY FINDINGS AMULABLE PRIOR TO
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filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to bunda, PORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic er	E COMPLETED BY PHYSICIAN: MEDICAL	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER: 1	DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS CONTributing to death BUTE TO CAUSE (HOSPITAL: Inpetient 2 ER/Out 28e. DATE OF INJURY (Month Day, Ver) 28e. PLACE OF INJURY building, etc. (Special Control of the besis of examination)	A CONSEDUENCE A CONSEDUENCE but not resulting DF DEATH 28. PLACE OF OR lipstlent 3 □ DOA 28b. T Y — At home, term scrify) wiedge, death occurrent on end/or investigation	OF): OF):	UNCERTA One) Home 5 Residence C. INJURY AT WORK? YES 2 ND office date end place, end du lon, death occured at th	28d. OESCRIBE 28d. OESCRIBE 28f. LOCATION (City or fown,	PREPORMED? YES 2 MO Street and Number or State) Individual stated on the control of the contr	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO RED Rural Route Number, Seuse(e) end manner se stated. SIGNED (Month, Day, Year)



DIVISION OF VITAL RECORDS, P.O. BOX 68760

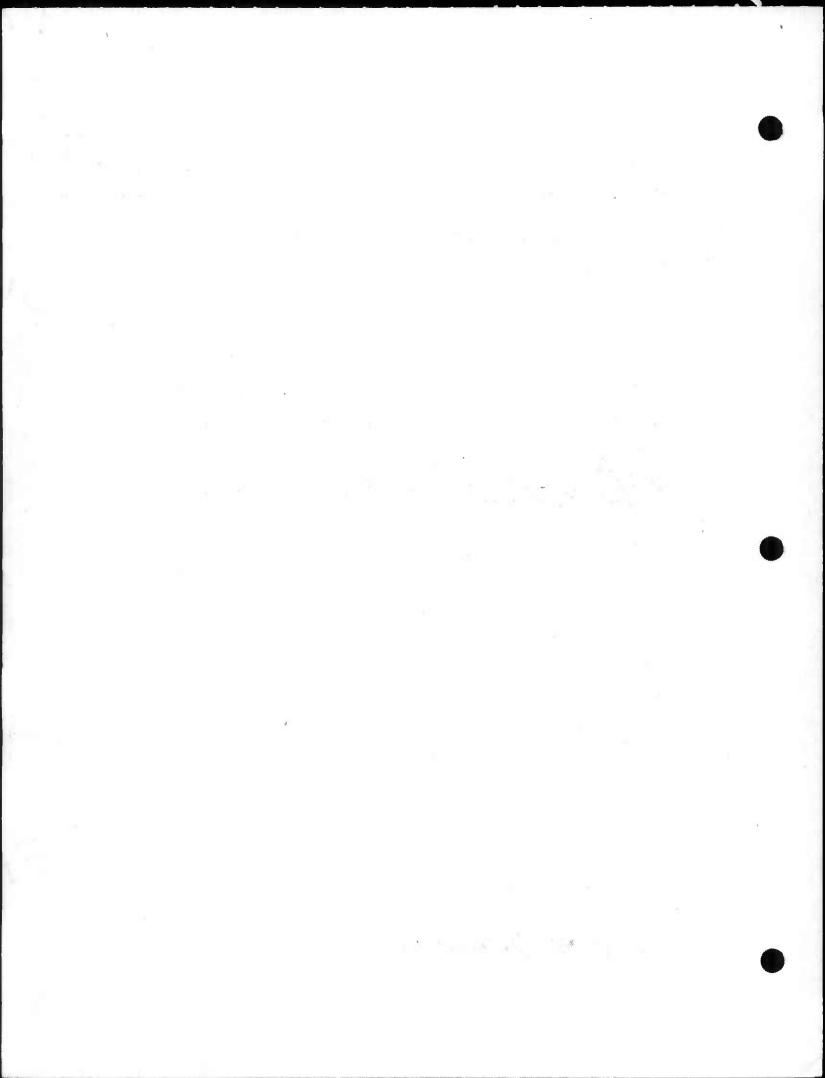
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 55 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

FilmG, 725, items #3,9a,9b,9c,23I-A,24A,25,26,27,29A,29D, 7/12/95, per physician,cyw state STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1 - FOR STATE REGISTRAR

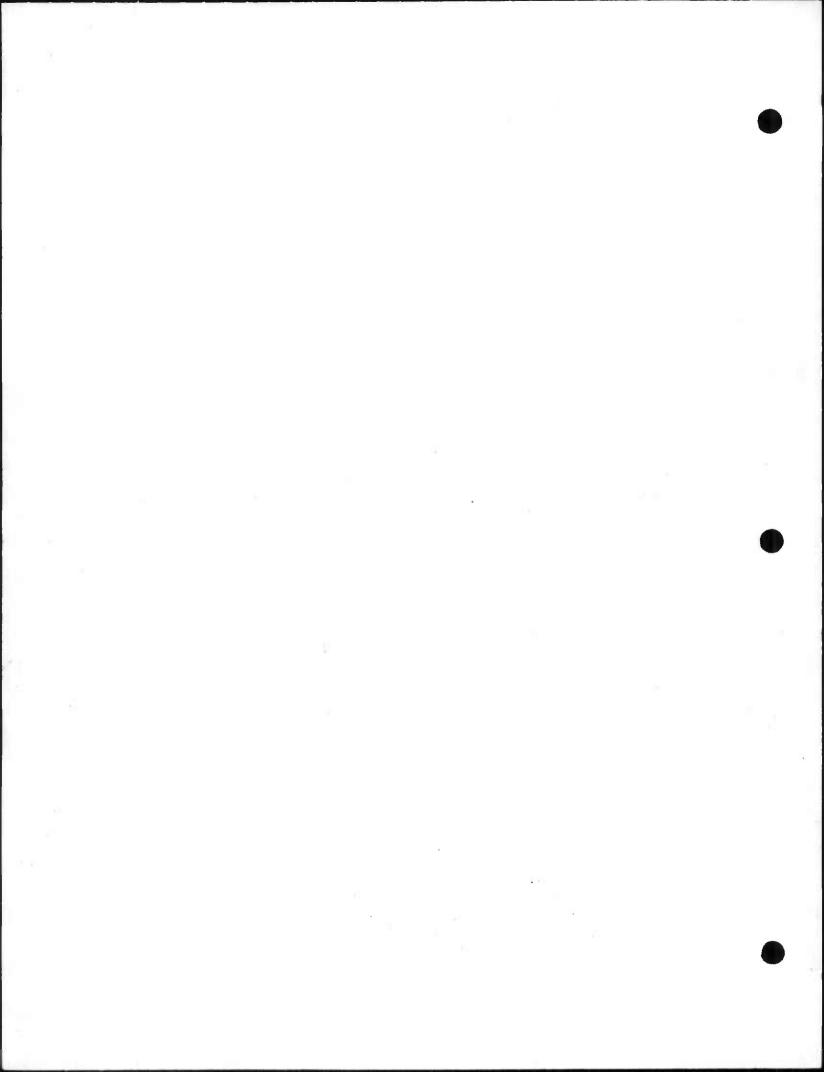
	1. DECEOENT'S NAME (First	, Middle, Last)								2. DATE OF D				3. TIME OF DEATH
	LOUIS J		YACOVIS	SI. SR.						JULY	9.	1	995	9:30 _p
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7 DATE OF B	IRTN	Ť	8. BIRTH	PLACE (State or Foreign
	717-07-6475		1 💹 M 2 🗌 F	80	YRS.	MONTHS	DAYS	HOURS	MIN.	JAN . 25	,191.	5	Country	LAND
m	9a. FACILITY NAME (If not in							OR LOCATION	_				NTY OF D	NI A
DIRECTOR	2629 WEGWO		NE			BA.	LTIN	IORE	CTTA			-BA	LTIM	ORE CITY
<u> </u>	10a. STATE	10b. COUNTY			10c. CITY	, TOWN C	OR LOCA	TION						10d. INSIDE CITY
	MARYLAND	ВА	LTIMORE	CITY			BAL	TIMOF	RE					1 X YES 2 NO
FUNERAL	100. STREET AND NUMBER 2029 WEGWOR	TH IAM	TF.				10	f. ZIP CODI	2123			1		HAT COUNTRY?
¥ l	11. MARITAL STATUS	III LAN		IT EVER IN U.S. ARM	450	- 10							U.S.	
	1 Never Married 2 🔀	Married	FORCES? 1	YES 2 N	D		If yes, sp	ecify Cube	n, Maxica	iC ORIGIN? (Sp n, Puerto Rican,		r No-	Black	— American Indian, , White, etc.
BY	3 Widowed 4 Divo	rced	IF TES, GIVE V	AN ON DATES			T YES	2 X NO	Specify	,			Specif	WHITE
	15. DEC (Specify only	EDENT'S EDUC y highest grade	CATION completed)	(GA	CEDENT'S	ork done o	CCUPATION	ON ost of working	ng .	16b. KIN(OF BUSIN	IESS/IND	USTRY	
COMPLETED	Elementary/Secondary (0 9TH GRADE	1-12)	College (1-4 or 5	14	CRACK	,				PEN	NSYL	VANI	A RA	ILROAD
BE CO	17. FATHER'S NAME (First, M JOHN YACOVI			-					ER'S NAI	ME (First, Middle CTA (, Maiden Su UNKN(-	
TO B	MRS. BEULAH		ISSI	19b	MAILING 629	ADDRESS WEGW	ORT	nnd Number H LAN	or Rural R	BALTIM	ORE,	State, Zip		230
	20a. METHOD OF DISPOSITI	n 3 🗆 Remo	ovel from State	20b. PLACEA cemetery, cren LORRAI	ND DATEO	F DISPOS	CEM	me of	,	7/14	BAL			wn, Steta
	21. SIGNATURE OF FUNERA	and the latest and th	ENSEE /	/ - A	NL I	32	NAME A	ND ADORES	SS OF FAC	YTUK			KE	
_	Teu	esa	L	Klu	8	41	07 V	ILKE	NS A	L HOME VENUE ·	- BAI	TIM	ORE,	MD 21229
	23. PART I. Enter the di shock, or he IMMEDIATE CAUSE (Fin disease or condition resulting in death)	eart fallure. L	List only one car	(DR AS A CONSEO		((n ~	or reapira		•at,	Approximata interval Between Onset and Death
CERTIFICATION	Sequentially list condition if any, leading to immediate. Enter UNDERLY! CAUSE (Disease or Injuithat initiated events	diate ING Iry		(OR AS A CONSEQ	A-0-4 2.5								-	
ERT	resulting in deeth) LAS		1											
- 11	PART II. Other aignifica	nt conditions	s contributing to	deeth but not re	sulting in	the un	deriyin	g ceuse g	iven in i	Part i, 24a.	WAS AN AU	JTOPSY	24b.	WERE AUTOPSY FINDINGS
DICAL											PERFORMI			AVAILABLE PRIOR TO COMPLETION OF CAUSE
										_ ''	1 ES 2 K	JNO		OF DEATH? 1 YES 250-400-
ž	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF DEAT	TH YE	1 🗆 2	10 E	UNC	ERTAIN					
등	25. WAS CASE REFERRED TO EXAMINER?	D MEDICAL	HOSPITAL:	26. PLACE	OF DEATI									
	1 TYES 2 NO			ER/Outpatient 3		OTHER		e 5 💢 Re	sidence	8 Other (Spe	cify)			
BY PHYSICIAN:		Pending Investigation	28a. OATE DF (Month, D		28b. TIME INJU	OF JRY M	WC	URY AT PRK? YES 2	NO	28d. DESCRIBE	E HOW INJ	URY OCC	CURED	
- 4	3 Sulcida 6	Could not be determined	28e. PLACE D building,	F INJURY — At honests. (Specify)	ne, farm, si	reet, facto	ory, offic	•		28f. LOCATION City or Tow	(Street and	Number	or Rural Ri	oute Number,
COMPLETED	29e. CERTIFIER 1 CERT	IFYING PNYSIC	CIAN: To the best of	my knowledge, dea	th occurre	d at the ti	me, data	and place,	and dua	to the cause(s)	and menne	or on state	ed.	H
BE CO	296. SIGNATURE AND TITLE			sammation and/or in	rveatigation	i, in my o	pinion, d		NSE NUM				E SIGNED	and menner as stated. (Month, Day, Year)
	13		7 727	V	2			I	21	1293	3		7/	11/95
	DR. BRUCE I						UE -	· (SU	ITE	108-SE	TON E	BLDG) BAL	ro.,MD21229
	31. DATE FILED (Month, Day,	2 1995	32 REGISTRA	R'S EIGNATURE	lall									



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DIVISION OF VITAL RECORDS, P.O. BOX 68760	. (
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH JULY 7, YVONNE E. YANCEY 1995 3:45 P 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday. 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 JF YRS. 213-64-6929 APR. 40 19 55 19 MARYLAND Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY N/A 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY MARYLAND N/A BALTIMORE CITY 1X YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10a, CITIZEN OF WHAT COUNTRY? use as the bunial-transit 235 N. BOND 212 21213 Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married II yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 TYES 2 NO Specify. BY 3 Widowed 4 Divorced Specify: BLACK 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig H completely filled in by the funeral director, page 5 should be detached for College (1-4 or 5+) COMPL 12TH NONE N/A HOMEMAKER Once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname Te JAMES YANCEY ELLEN BRUNSON BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1235 N. BOND ST. BALTO, MD. STACY BRADFORD 21213 must be 20a. METHOD OF DISPOSITION
1

Burlal 2 □ Cremation 3 □ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE 4 Donation 5 Other (Specify) 7/14/95 BALTO, MD. ARBUTUS MEM. PARK. examiner 21 SGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY CALVIN B. SCRUGGS FUNERAL HOME 1412 PRESTON ST. BALTO, MD E 21213 the medical 23. PART I. Enter the diseases, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory errest, Approximata ahock, or heart failure. List only one cause on each line. Interval Between ō IMMEDIATE CAUSE (Final Onașt and Death cremation, disease or condition event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF hysician and com prior to bunial, i OBES 17 traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate physician cause. Enter UNDERLYING CAUSE (Disease or injury AIRWAY TIVE 1SEMSE other t DUE TO (OR AS A CONSEQUENCE OF that initiated events the attending p resulting in death) LAST ER TENSION 0 PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? PHYSICIAN: MEDICAL and a shows any 1 X YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO UNCERTAIN has by Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only on SPITAL OTHER: 1 YES 2 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 50 the 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED this c marked, Natural 1 YES 2 NO BY After death Accident 3 Guichite 28a. PLACE OF INJURY — Al home, farm, street, factory, offica building, etc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 COMPLETED 6 Could not be DIRECTOR: after 4 Homicide item 28 hours a 29a. CERTIFIER N: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE FUNERAL D be filed within 72 h IMPORTANT: It it (Check only one) MEDICAL/EXAMINE tion, in my opinion, death occured at the time, data and placa, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE DE CER 29c. LICENSE NUMBER BE 2 30. NAME AND ADDRESS OF PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

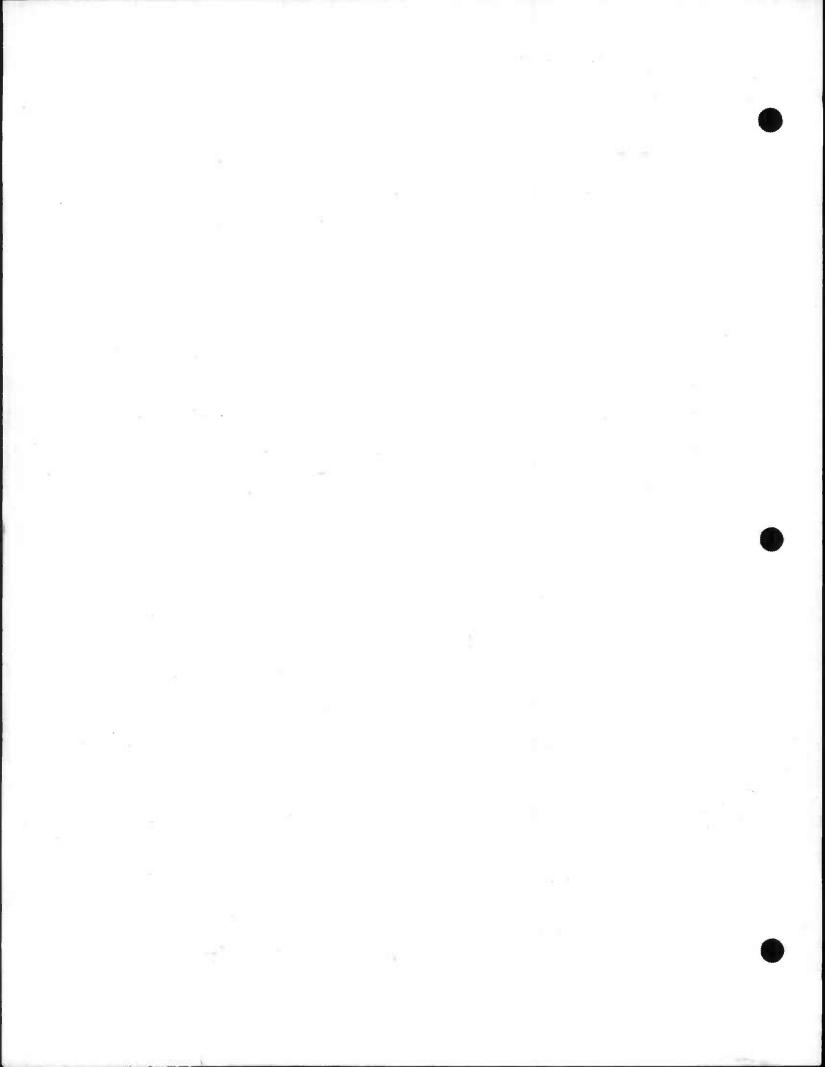


The hapital or attending physician.

DIVISION OF VITAL RECORDS

death.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral
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within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fu
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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

		Item1,g-725,7-12-95	,perr.n.,ak					a .	20982
		1 - FOR STATE REGISTRAR	STATE OF MARY		RTMENT OF H		ENTAL HYGIEN		
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	- 1	Rose B. Za	pora				A cross	6 9	5 8:45 P "
	- 1	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)
		198-05-1181		83 yrs.	aonina dan	HOOKS MIN.	Dec. 27,1	911	Pennsylvania
	~	9a. FACILITY NAME (If not institution, give si	treet and number)		9b. CITY, TOWN O	R LOCATION OF DEA	тн	9c. COUNTY	OF DEATH
	5	Johns Hopkins B	agview Medic	cal Ctr.	Balt	imore Cit	ty	N,	/A
	<u>입</u>	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY	r	10c. C/1	Y, TOWN OR LOCATI	ON			10d. INSIDE CITY
	DIRECTOR	Maryland	Baltimore	2		Dr	ındalk		LIMITS?
	A	10e. STREET AND NUMBER	<u> Dicoognovia</u>	<u> </u>	10f.	ZIP CODE	a racocic	10g. CITIZEI	N OF WHAT COUNTRY?
	FUNERAL	3459 Dunhaven R	load			212	722	Uni	ted States
	5	11. MARITAL STATUS	12 WAS DECEDENT EVED	IN U.S. ARMED		NDENT OF HISPANIC	ORIGIN? (Specify Yes		RACE — American Indian, Bleck, White, etc.
-	BY	1 Never Married 2 Married 3 X Widowed 4 Divorced	FORCES? 1 YES	DATES NO	If yes, spe	cify Cuban, Mexican, 2 NO Specify:	Puerto Rican, etc.)		0 4
- 1	- 1								white
	핃	15. DECEDENT'S EDUC (Specify only highest grade		16a, DECEDENT'S	USUAL OCCUPATION Work done during mos se retired.)	N t of working	16b. KIND OF BUS	SINESS/INDUS	TRY
	الة	Elementary/Secondary (0-12)	College (1-4 or 5+)		ustrial		0:01	2 Mill	
once.	OMPLETED	8 YOAKA 17. FATHER'S NAME (First, Middle, Lest)		Inta	isviai	18 MOTHED'S NAME	E (First, Middle, Maiden		
8	闔	Michael Antonacc	i				tta Scutto		
ŽΛ	岡	19e. INFORMANT'S NAME (Type/Print)	4	19b. MAILING	ADDRESS (Street an		ute Number, City or Town		ode)
	104	Valentine Zapora					altimore,		1222
1	2	20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Remo 4 Donation 5 Other (Specify)		Db. PLACE AND DATE Implery, crematory or C SACTED H			110/95 B	cation — cin altimo	re, MD
ner		21. SIGNATURE OF FUHERAL SERVICE LIC		11					ndalk, Inc.
xam		DI halm	FX	1/			. Dundal		21222
cal		23. PART i. Enter the diseases, or o	complications that cause	ed the deeth. Do					
Be		shock, or heart failure.	List only one cause on	each ilne.					interval Between Onset and Daath
ŧ.		iMMEDIATE CAUSE (Fine) disease or condition	Myaca	.cd ' . l	TINE	arcti-			
vent,	Í	resulting in death)	DUE TO (OR AS	A CONSEQUENCE O	D:	21 6 110	in.		40 days
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ury, o	S	CAUSE (Disease or Injury that initiated events	c. HKDS DUE TO (OR AS	A CONSEQUENCE O	F):		nrt i. 24a. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS
any injury.	DICAL CE	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	c. HKDS DUE TO (OR AS	A CONSEQUENCE O	F):			AUTOPSY MED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE
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or item 23 shows any injury,	PHYSICIAN: MEDICAL CE	Cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition DID TOBACCO USE CONTE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	DUE TO (OR AS DUE TO (OR AS d. RIBUTE TO CAUSE (but not resulting DF DEATH YI 26. PLACE OF DEA tpetient 3 □ DOA	in the underlying In the underlying In (Check only one) OTHER: 4 Nursing Home IN URY 28c. INJU	UNCERTAIN 5 - Residence 8 1887 AT 18	art i. 24a. WAS AN PERFOR	AUTOPSY MED? NO	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
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m 28 is marked, or item 23 shows any injury,	ETED BY PHYSICIAN: MEDICAL CE	CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition DID TOBACCO USE CONTE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined	DUE TO (OR AS DUE TO (OR AS d. RIBUTE TO CAUSE (FIOSPITAL: 1 Inpetient 2 = ER/Out 28a. DATE OF INJURY	but not resulting DF DEATH YI 28. PLACE OF DEA tpetlent 3 □ DOA 28b. Tin NN.	in the underlying In the underlying In the underlying In (Check only one) OTHER: 4 Nursing Home 120 280 INJU	UNCERTAIN 5 - Residence 8 RRY AT ES 2 - NO	art i. 24a. WAS AN PERFOR 1 YES 2	AUTOPSY MED? NO NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

6 PHYSICIAN: The law remaines that the death certificate be executed with the hours after death. Pans 6 may be retained by the house about the second of the	TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	nn win the State Dept. on Health and Mental Hyglene prior to burial, cremination, or removal. In a state of the state of t	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The	O THE FUNERAL DIRECTOR: After this certificate h	be filed within 72 hours after death with the State is impropried, or item	

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

							T DEAL		REG. NO.			
	1. DECEDENT'S NAME (First	Middle, Lest)	10	TE	05				DATE OF DEATH DA	NY.	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	0011	1 1-1	1010	·HC				JULY O	7	35	10.55 A) M
1 1	212-74-9399	===	5. SEX 1 M 2 N F	5. AGE (In yrs. las 100	t birthday) YRS.	MONTHS DAY		4 HRS. 7.	OBTE OF BIRTH (Month, Day, Year) DEC. 11,	1894	8. BIRTH Country	PLACE (State or Foreign y) yland
	9a. FACILITY NAME (If not in			100		OL OITY TOU	#					
5	Union ME		1 1	spita	/		NOR LOCATION		1-1	9c. COU	N/A	
DIRECTOR	RESIDENCE OF DEC	EDENT	CCC 170	JP III CA				ore	4 49		21/ -	
	10a. STATE	10b. COUNTY	27/4			, TOWN OR LO						10d. INSIDE CITY LIMITS?
	Maryland		N/A		Balt	timore	City					1 X YES 2 NO
₹	100. STREET AND NUMBER						101. ZIP CODE			10g. CITI	ZEN OF W	VHAT COUNTRY?
FUNERAL	1705 South 1	Road.					2120	9			U.S	S.A.
	11. MARITAL STATUS 1 Never Married 2		12. WAS DECEDENT FORCES? 1	EVER IN U.S. AR	MED	13. WAS I	DECENDENT OF	HISPANIC Mayloon	ORIGIN? (Specify Yea Puerto Ricen, etc.)	or No-		— American Indian, k, White, etc.
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8	17. FATHER'S NAME (First, M	iddie, Lest)					18. MOTHE	R'S NAME	(First, Middle, Maiden	Sumame)		
BE C	Samue1			Jon	es		Mo1			,	Ha	ance
0 0	19a, INFORMANT'S NAME (7			190	b. MAILING	ADDRESS (Stre	et and Number o	r Rural Rout	te Number, City or Town	n, State, Zip	Code)	
ř	C. Norman	Andreae	Jr.						re, Maryla)
	20a METHOD OF DISPOSITI	ION on 3 - Ramov	ral from Stata			F DISPOSITION				CATION —		
	4 Donation 5 Other	(Specify)		Family	y Bur	iái Gr				ice F	rede	rick, Maryla
	21. SIGNATURE OF FUNERA	SERVICE LICE	NISEE				AND ADDRESS		efeld Hom	•		
	tohe	257	ah						Baltimor		arv1s	and 21212
	23 PART I. Whiter the di	seases, or co	mplications that	caused the de	ath. Do n	ot entar the	moda of dylng	g, auch s	e cardiac or respir	ratory arr	200	Approximate
	IMMEDIATE CAUSE (Fin	BEST TRINUTE. LI	IS! Offiv one cause	and done							cat,	
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

30. NAME AND ADDRESS OF PERSON WHO COM

OCIANDO

31. DATE FILEO (MOOTH, DBY VAR)

JUL 1 3 1995

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	Item20b,g-725,7-14	-95,perf.h.,	рс				95	20984		
_	FOR 1 - STATE REGISTRAR	STATE STATE STATE OF MARTLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE								
	1. DECEDENT'S NAME (First, Middle, Last) GERTRUBE AXE			EL		2. DATE OF DEATH MONTH DE	1995	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 108-28-8110		6. AGE (In yrs. lest birthday) 82 YRS.	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH	R BIRTH	PLACE (State or Abreign VORK		
R	9a. FACILITY NAME (If not institution, give stree' and number) NORTHWEST HOSPITAL CENTER				OR LOCATION OF DEATH NDALLSTOWN BALTIMORE					
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT		TOWN OR LOCATION 10d. INSIDE CITY							
	MARYLAND BALTIMORE 10s. STREET AND NUMBER				RANDALLSTOWN 1 TYPES 2 ND					
BE COMPLETED BY FUNERAL	3447 CARRIAGE HILL CIRCLE, APT. 102				101. ZIP CODE 109. CITIZEN DE USA			HAT COUNTRY?		
	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	11. MARITAL STATUS Never Married 2 Married Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 MD IF YES, GIVE WAR OR DATES			13. WAS DECENDENT DF HISPANIC DRIGIN? (Specify Yes or No-H yes, apocity, Cuban, Maxican, Puerto Rican, etc.) 1 VES 2 M ND Specify: WHITE					
	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)	UCATION fe completed) College (1-4 or 8 +)	USUAL OCCUPATION Work done during mose retired.)	DN st of working	16b. KIND OF BUS	BUSINESS/INDUSTRY				
	12 17. FATHER'S NAME (First, Middle, Lest)		HOUSEWIFE 18. MOTHER'S NAME (First, Middle, Maide				OWN HOME			
	SAMUEL	K	APLAN		MIN	INIE UNKNOWN				
2	196. INFORMANT'S NAME (TyperPrint) MR. JACK AXEL 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3447 CARRIAGE HILL CIR., APT. 102 RANDALLSTOWN,									
	20a_METHDD DF DISPOSITION 1 Description 3 Removal from State 2 Description 3 Removal from State 2 Description 3 Removal from State 2 Description 5 Description State 2 Description State 2 Description State 2 Description State 2 Description State 2 Description State 2 Description State 2 Description State 2 Description State 2 Description State 2 Description State 2 Description State 2 Description State 2 Description State 2 Description State 2 Description State 2 Description State 3 Description State 3 Description State 4									
100	21. SIGNATURE OF FUNERAL SERVICE LI	1. SIGNATURE OF FUNERAL SERVICE LICENSEE			22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC.					
	23. PART I. Enter the diseases, or complications that caused the death. Do not an shock, or heart failure. List only one cause on each line.				6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 nter the mode of dyling, such as cardiac or respiratory arrest, Approximate					
	IMMEDIATE CAUSE (Finsi disease or condition resulting in dasth) ACLU TO INSTERLED MYOCANDIAL INTERCED. Interval Betwee Onset and Date of the Control of th									
	DUE TO (DR AS A CONSEDUENCE DF):									
RTIFICATION	Sequentially list conditions, If sny, leading to immediate cause. Enter UNDERLYING									
	CAUSE (Disease or Injury that Initiated events DUE TO (DR AS A CONSEDUENCE OF):									
CAL CE	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY FINDINGS PERFORMED? PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY FINDINGS PART OF THE PROPERTY OF TH									
PHYSICIAN: MEDICAL	CONCESTIVE HONT FAILURE : DINCET'S MELLITUS: DENENTED 1 VES 2 NO									
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)									
rsic	EXAMINER?	EXAMINER? HOSPITAL: OTHER-								
ву РНУ	27. MANNER OF DEATH 1 Netural 5 Pending Investigation	28a. DATE OF IN (Month, Day,	Year) INJ	URY WO	28c. INJURY AT WORK? 1 VES 2 NO 28d. DESCRIBE HOW INJURY OCCURED					
	2 Accident Investigation 3 Suicide 8 Could not be detarmined 28a. PLACE DF INJURY — At home, farm, street, building, etc. (Specify)				factory, office 281. LOCATION (Street and Number or Rural Route Number, City or Yown, State)					
COMPLET	29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.									
BE CO	2 MEDICAL EXAMINER: In the beals of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(a) and manner as stated. 29b. BIGHATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)									
5	30. NAME AND ADDRESS OF PERSON WI	HO COMPLETED CAUSE	OF DEATH (ITEM 27) (Tops	Drillon)	2195	22	> Jaly	10, 1225		

29c. LICENSE NUMBER
D (958 29d. DATE SIGNED (Month, Day, Year)

Jilly 10, 188 KANDAUSTOWN Med. 2113 MD

TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO.								
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH 3. TIME OF DEATH			
- 4	Joshua	Harper	Ar	Armacost		July 11 1995		9:55 p w	
- 3	4. SOCIAL SECURITY NUMBER			ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	6. BIRT	HPLACE (State or Foreign	
	213-38-731/ ₄ 9e. FACILITY NAME (If not institution, give	1 M 2 F Street and number)	O2		OR LOCATION OF DEA	ec. 16, 1		RYLAND	
DIRECTOR	Broadmead RESIDENCE OF DECEDENT			COCKEYSVILLE			BALTIMORE		
EC	10a. STATE 10b. COUNTY		10c. CITY,	10c. CITY, TOWN OR LOCATION			10d. INSIDE CITY		
	MARYLAND BALTIMORE			COCKEYS	VILLE	LIMITS?		LIMITS?	
FUNERAL	100. STREET AND NUMBER			101, ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?		
N N	13801 York Rd. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARI			21030			USA		
	1 Never Married 2 Married FORCES? 1 YES 2		2 100	If yea, specify Cuban, Maxico		n, Puarlo Rican, atc.) Black,		CE — American Indian, ck, White, alc.	
B√	3 ☐ Widowed 4 ☐ Divorced IF YES, GIVE WAR OR DATES			1 YES 2X NO Specify:			Specify: WHITE		
回				DECEDENT'S USUAL OCCUPATION Give kind of work done during most of working			F BUSINESS/INDUSTRY		
COMPLETED	Elementary/Secondary (0-12)	college (1-4 or 5+)		Medical Doctor			V 1: 1		
NO.	17. FATNER'S NAME (First, Middle, Last)						Medical #E (First, Middle, Malden Sumame)		
	William Melc	hior Armacost				t Elizabe		or	
BE (19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AI	DORESS (Street e		ute Number, City or Town			
임	Robert W. Arm	acost	600	600 Edgevale Rd., Balto., MD. 21210					
	20a, METNOD OF DISPOSITION 1 A Burlal 2 Cremention 3 Ran	20b.	PLACE AND DATE OF	DISPOSITION (Na	me of	DATE 20c. LO	CATION — City or 1	lown, State	
-	4 Oonetion 5 Other (Specify)	toda (1)	adowbranc				stminste	r, MD	
	Bryan W. Clary			Lemmon Funeral Home of Dulaney V.				Valley, Inc	
_				10 W.	Padonia	Rd., Time	onium, M	D 21093	
	23. PART I. Enter the diseases, or complications that ceuced the deeth. Do not enter the mode of dying, such se cerdisc or respiratory errest, shock, or hear feliure. List only one ceuce on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	Sequentially liet conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): C. Z. T. OUE TO (OR AS A CONSEQUENCE OF): d							3 days	
PHYSICIAN: MEDICAL	PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO								
AN	25. WAS CASE REFERRED TO MEDICAL		6. PLACE OF DEATH		UNCERTAIN				
<u>i</u>	EXAMINER?	HOSPITAL:	0	TAER:					
¥ I	27. MANNER OF DEATH	1 Inpatiant 2 ER/Outpa	28b. TIME		5 Raaldenca 6	Other (Specify)	ILIBY OCCUBED		
	1 Natural 5 Pending Investigation	(Month, Day, Year)	INJUR	Y WO	RK?	IOU. DESCRIBE NOW II	AJORY OCCURED		
ED BY	Could not be determined Could not be det			ne, ferm, streel, factory, offica		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
9	29a. CERTIFIER . A FEBRUARY BANGGRAM Y. M. S. S. S. S. S. S. S. S. S. S. S. S. S.								
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BE C	296. SIGNATURE AND DILE OF CERTIFIE		>		29c. EICENSE NUMB			D (Month, Day, Year)	
2	MAME AND ADDRESS OF PRISON WIN	O COMPLETEO CAUSE OF OEA	TH (ITEM 27) (Type, Pri	int)	NOOL		<u> </u>	2/95	
	13801 40	ete Roas	2 Ca	chers	VILLE	MD.	2103	0	
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	1. DECEDENT'S NAME (First, Middle, Last) DOROTHY	M. AUGUS	ST				2. DATE OF DEATH	DAY 95	YEAR	3. TIME OF DEATH 2:45 A
	4 SOCIAL SECURITY NUMBER 219-18-7375						5. 7. DATE OF BIRTH (Morrity, Day, Yea 4-28-25		8. BIRTH Countr	PLACE (State or Foreign
OR	99. FACILITY NAME (If not institution, give st MANOR CARE TOWSON	reet and number)			Y, TOWN O	R LOCATION OF		9c. COUNTY OF DEATH BALTIMORE		
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY MARYLAND	N/A		CITY, TOWN		ION				10d. INSIDE CITY LIMITS?
FUNERAL	100. STREET AND NUMBER 712 S. POTOMAC STR		10f. ZIP CODE						TIZEN OF W	1 X YES 2 NO
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVEN FORCES? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	YES 2 NO	13.	If yes, spe	ENDENT OF HIS octy Cuben, Mar 20 NO Sp	PANIC ORIGIN? (Specify rican, Puarto Bican, etc., ecify:	Yea or No-	14. RACE	— American Indian, , White, etc.
LETED	15. DECEDENT'S EDUC (Specify only highest grade)	CATION completed) College (1-4 or 5+)	(Give kin life. Do N	NT'S USUAL (d of work done OT use retired.)	during mos	N st of working	16b. KIND OF	BUSINESS/IN	IDUSTRY	
COMPLET	17. FATHER'S NAME (First, Middle, Last) IGNATIUS AUGUST		STENO	CLERK			OFFIC	den Surname)		
TO BE	190. INFORMANT'S NAME (Type/Print) MR. ANDREW I FURY	CLARA C. KOLKOWSKI 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 EAST JOPPA ROAD BALTO. MD. 21286								
	20a. METHOD OF DISPOSITION 1 (X) Burlat 2 Cremation 3 Ramo 4 Donation 5 Other (Specify) 21 SIGNATURE OF FUNERAL SERVICE (CC		20b. PLACE AND D	EART K	OF MA	ARY CEM D ADORESS OF ROWSKI	FACILITY FUNERAL HO		CO. M	
	23. PART I. Enter the diseases, or c	omplications that cou	and the death				T. BALTO.			
7	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	. Care	AS A CONSEQUENCE	na 0	1	Brd		apiratory sr	rrest,	
ERTIFICATION	IMMEDIATE CAUSE (Finel disease or condition	DUE TO (OR /	in each line.	DE OF):	1			apiratory sr	rrest,	Interval Betw
EDICAL C	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR /	AS A CONSEQUENCE	DE OF):	16	Bra	In Part i. 24s. WAS PERI	AN AUTOPSY FORMEO?	24b.	WERE AUTOPSY FINOR AVAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH?
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EDICAL C	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated eventa resulting in deeth) LAST PART II. Other significent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	DUE TO (OR /	AS A CONSEQUENCE AS A CONSEQU	YES DEATH (Check	NO Only one) Peraling Home 28c. INJU	Ceuse given UNCERTA 5 □ Residence	In Part i. 24a. WAS PERI 1 YES AIN Other (Specify)	AN AUTOPSY ORMEO? 2 AND WINJURY OC	24b.	WERE AUTOPSY FINOI MAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO

2/2,

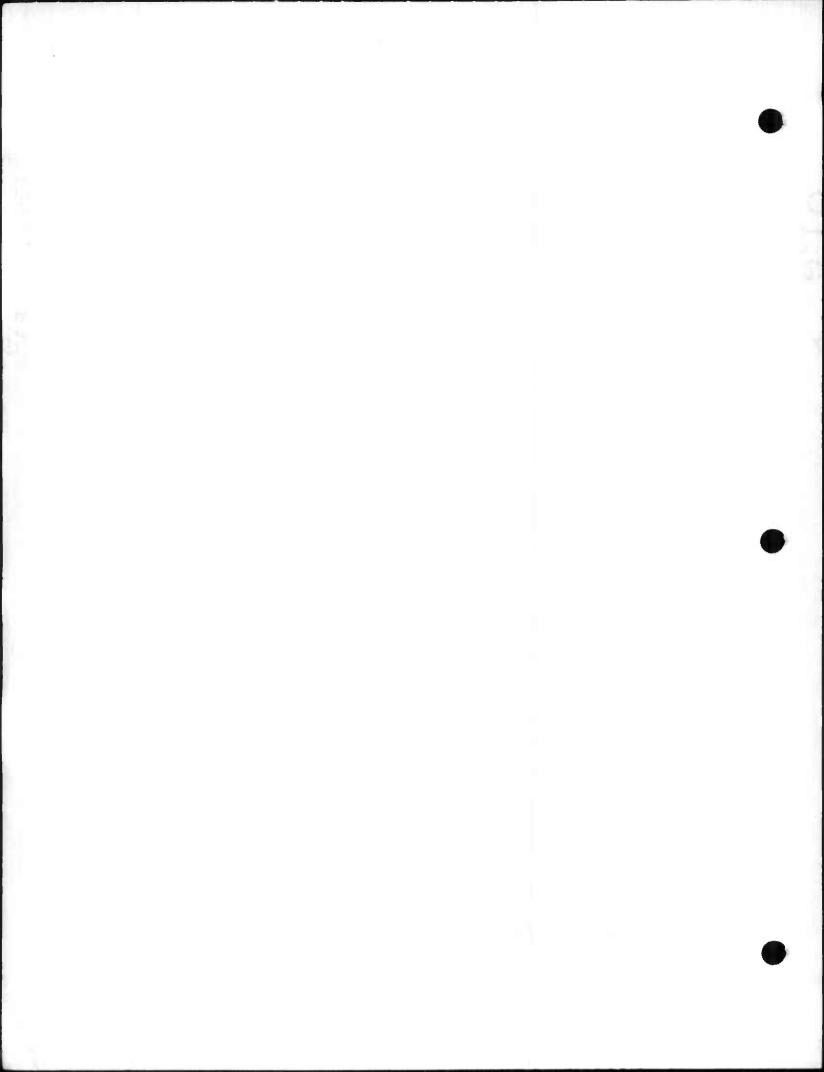
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

	1. DECEDENT'S NAME (First	Adjoint Land				.071	- 01	DEA		HEG. NO	·			
	, DECEMENT 3 NAME (F#3)	, wildow, Lasij	RAYMON	DE.B.	ANE					2. DATE OF DEATH MONTH D	9	YEAR 5	3. TIME OF DEATH 4:38 A M	
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs: les	t birthday)	IF UNDE	T YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH		6. BIRTH	IPLACE (State or Foreign	
	066-36-10:		1 📈 M 2 🗆 F	50	YRS.	MONTHS	DAYS	TOWN OR LOCATION OF DEATH				NE W	YORK	
l cc				000174		1		-		АТН	9c. COUNTY OF DEATH			
DIRECTOR	CARROLL CO	J. GE	NERAL H	USPITAL	-	MA	NCH	ESTE	:R		CARROLL CO.			
E I	10a. STATE	10b. COUNTY	1		10c. C/1	ry, town	OR LOCA	TION			10d, INSIDE CITY			
	MARYLAND		CARROL	L CO.	MA	NCH	EST	ER			1 TES 2 X NO			
FUNERAL	3070 MONRO		DEET				100	f. ZIP COD			10g. CITIZEN OF WHAT COUNTRY?			
N I	11. MARITAL STATUS	JL J11	12. WAS DECEDEN	T EVED IN II S AD	MED	1 40		2110				SA		
	1 Never Married 2 🔀	Married	FORCES? 1	X YES 2 D	10		If yes, sp	ecify Cuba	in, Maxican,	C ORIGIN? (Specify Yes Puerto Rican, etc.)	or No-		— American Indian, c, White, atc.	
BY	3 Widowed 4 Divo	rced	FORCES? 1 IF YES, GIVE Y	ETNAM			1 U YES	2 (X NO	Specify:			Special W	ÎTE	
윤	15. DEC (Specify only	EDENT'S EDU	CATION completed)			USUAL O		ON ost of working	na	16b. KIND OF BUS	SINESS/INC	DUSTRY		
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COMPLET	17. FATHER'S NAME (First, M	Valenta d = 100		SEC	JURI	TY	UAl	_		MILIT				
	CHARLE	D				11.7		E (First, Middle, Maiden						
BE	19a. INFORMANT'S NAME (7)		DAIL J		. MAILING	ADDRES	S (Street s			SCHRAE		Codel		
인	MRS. JOAN			30	070	MON	ROE	STR	EET	MANCHES	TER,	MD.	21102	
	20a METHOD OF DISPOSITI 1 A Buriel 2 Crematio 4 Donation 5 Other	n 3 🗆 Reme	ovel from State	20b, PLACE	NODATE	OFDISPOS	ITION (Na	ame of		7-3 BAL	CATION -	City or To	un State	
	24 SIGNATURE OF FUNERAL	L SERVICE LIC	ENSEE	PIN L	710014	22.	NAME AL	ND ADDRE	SS OF FACI	LITY				
	War less	XX	MANI	nede		K	ACZ(201	DROW Nija	SKI	FUNERAL	HOM	E	MD. 21222	
	23. PART I. Enter the di	seeses, or c	omplications the	caused the de	eth. Do	not enter	tha mo	de of dy	ing, such	ss cardiac or respi	ratory sri	rest,	Approximate	
	IMMEDIATE CAUSE (Fin	ai	List only dha cau	W D				, 4					Interval Batween Onset and Dasth	
	disease or condition resulting in death)	→ ,	Ve	M ti cula	× 1	-ib/	illa	tron						
z			Con	COTAS A CONSEC	DUENCE O	101	4/	Dea	14.51	in Dic	ease 90min			
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FIC	CAUSE (Disease or Inju		OUE TO	(OR AS A CONSEC	UENCE O	F):								
ERT	resulting in death) LAS	T (1											
	PART il. Other eignifice	nt condition	contributing to	deeth but not re	esuiting	in the ur	deriying	g ceuse g	given in P	ert i. 24a, WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS	
EDICAL										PERFOR	4		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
MEC											NO		OF DEATH? 1 YES 2 NO	
	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF DEA	TH YE	S 🔲 I	NO [UNC	ERTAIN	Ø			To tes a line	
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26. PLAC	E OF DEA	TH (Check								
YSI	1 TES 2 NO		1 🗍 Inpatient 2 🖟	ER/Outpetlant 3	DOA	OTHER		e 5 🗆 Re	sidence 8	Other (Specify)				
표	27. MANNER OF DEATH	Pending	28a. DATE OF (Month, Da	ey, Year)	28b. TIM	IE OF	28c. INJ WO	URY AT		28d. DESCRIBE HOW II	NJURY OC	CURED		
B	2 Accident	rending nvestigation		/A		M		rES 2	NO					
E		Could not be setarmined	28e. PLACE Of building,	FINJURY — At horetc. (Specify)	ne, farm,	atreet, fact	ory, office	•	1	City or Town, State)	ind Number	or Rural A	oute Number,	
	29a. CERTIFIER	IEVING PHYSIC	CIAN: To the heat of	- boundade de						/2				
COMPLETED										o the cause(a) and man			end manner es stated.	
BE C	29b. SIGNATURE AND TITLE	OF CERTIFIER	10					29c. LICE	NSE NUMB	ER	29d. DAT	E SIGNED	(Month, Day, Year)	
10	30. NAME AND ADDRESS OF	PERSON WHI	COMPLETED CALL	Has A	(.)	Orient		7	24/	401	>	61	30/95	
	Departa	ent c	Imer gence	Medi			coll	Count	4 Ger	neval Hos	o. Set	West	minuster MD	
	31. DATE FILED (Month, Day)	Jaly	The state of	A LANGURE									21157	
U.	001 1 9 100	0												



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DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be emouted within the mount after the fact that the matrices	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and competity flied in by the funeral director, large 5 shows be filed within 72 hours after death with the State Dept. of Health and Mental Mygiene prior to bunke, cremitation, or remove.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified
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the hura transit permit. Pages 1, 2, 3 should

	1 - FOR STATE REGISTRAR	STATE (RTMENT OF			ENTAL HYGIE			
	1. DECEOENT'S NAME (First, Mid	idle, Last)						2. DATE OF DEATH			3. TIME OF DEATH
	Wesley	Evans Ba	aynes, Ji						DAY 1995	YEAR	unknown M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yr.	s. lest birthdey)			24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTH	IPLACE (State or Foreign
	212-32-0477	1 M 2		YRS.	MONTHS DAYS	HOURS	MIN.		L934	MAI	RYLAND
~	9a. FACILITY NAME (If not institut		or)		9b. CITY, TOW				DEATH		
5		eoho Road			SPAR	KS			MORE		
EC	10e. STATE 10	b. COUNTY		10c. Cl	TY, TOWN OR LO	ATION					10d. INSIDE CITY
- DIRECTOR	MARYLAND I	BALTIMORE		S	PARKS			50			LIMITS? 1 YES 2 X NO
BY FUNERAL	16116 Yes	oho Rd.				2115				SA	WHAT COUNTRY?
5	11. MARITAL STATUS		EDENT EVER IN U.S	ARMED	13. WAS D	ECENDENT C	F HISPANIC	ORIGIN? (Specify Y	es or No-	14. RACE	- American Indian,
7	1 Never Married 2 Mar 3 Widowed 4 Divorced	IE VES G	IVE WAR OR DATES			epocity Cube ES 2 NO		Puerto Rican, etc.)		Speci	k, White, etc.
1200										-	ITE
#	(Specify only high	NT'S EDUCATION heat grade completed)		(Give kind of life. Do NOT u	Work done during	TION most of workin	g	18b. KIND OF BI	USINESS/IND	USTRY	
то ве ефинсетер	Elementary/Secondary (0-12)	College (1-4	or 5 +)		nnel Ex	ecuti	ve	Banki	ng		
e de	17. FATHER'S NAME (First, Middle		- 0					E (First, Middle, Maide		Do	erflein
98		vans Bayne	s, Sr.					llie Doe		1	01120211
2	19a. INFORMANT'S NAME (Type/F Alice Bayne							ute Number, City or To		Code)	
1	20a. METHOD OF DISPOSITION	-5	1				Spar	ks, MD 2			
	1 M Buriel 2 Cremation :	Ramoval from Stat	20b. PLA cemetery	CE AND DATE , crematory or o	of Disposition of the of Fai	Name of		JULY Baltimore, MD			
	21. SIGNATURE OF FUNDIAL SE		1 6	ardens		AND ADDRES	SS OF FACIL		altimo	re,	MD
	1 Du	Re D.C.	large		Lemm	on Fu	neral	Home of	Dular	ey '	Valley, INC.
_	Brya	W. Clary	//	10 W. Padonia Rd., Timonium, N							21093
	shock, or heart	ses, or complications sallure. List only one	cause on each	I death. Do lina.	not entar tha r	noda of dyl	ng, auch	aa cardlac or reap	piratory arre	est,	Approximate Interval Between
	IMMEDIATE CAUSE Final	j L	1.1	1							Onset and Death
	resulting in death)	a	E TO MAS A CON	ins	um						
	1	DU	E TO OH AS A COP	SEQUENCE C	NF):						
_	ŀ	_ 4	1.00	11-0	120000	4					1
NOI	Sequentially list conditions		M PER	ISEQUENCE O	Sem i	1	1				
CATION	If any, leading to immediate cause. Enter UNDERLYING		TE TO COM AS A COM	MPI ISEQUENCE O	SUM W	PAR	2.	ist in	lus s	An	1
IFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	· A	E TO GOT AS A CON	ISEQUENCE O	Dem i	oba	rl.	g1 in	aro	An	
ERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	· A	(BA)	ISEQUENCE O	Dem i	oba	rd.	gt in	aro	An	
L CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. fou	E TO (OH AS A CON		/			•			
4	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	c. fou	E TO (OH AS A CON		/			•			WERE AUTOPSY FINDINGS AWILABLE PRIOR TO
A	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	d	E TO (OH AS A CON		/			•	N AUTOPSY PRMED?		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
4	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	c. Jou	E TO (69) AS A CON	ot resulting	In the underly	ng cause (jiven in Pr	PERFO	N AUTOPSY PRMED?		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
4	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. Jou d	g to death but n	ot resulting	In the underly	ng cause ç		PERFO	N AUTOPSY PRMED?		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
4	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificant of the cause of the c	c. Jou d. CONTRIBUTE TO	g to death but n	ot resulting EATH YI LACE OF DEA	In the underly ES NO ITN (Check only on OTHER:	ng cause g	ERTAIN	ert I. 24a. WAS AI PERFO	N AUTOPSY PRMED?		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
4	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART 11. Other algnificant of the cause of the c	c. Jou d. CONTRIBUTE TO	E TO GET AS A CON	EATH YILACE OF DEA	In the underly ES NO ITN (Check only on OTHER: 4 Nursing N AE OF 28c. I	ng cause g	ERTAIN	ert I. 24a. WAS AI PERFO	N AUTOPSY PRMED? 2	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant of the cause of the c	c. Jou d. CONTRIBUTE TO	E TO (eA AS A COR	EATH YILACE OF DEA	In the underly ES NO IN (Check only on OTHER: 4 Nursing No	UNC	ERTAIN	ert I. 24a. WAS AI PERFO	N AUTOPSY PRMED? 2	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant of the cause of the c	c. Jou d. CONTRIBUTE TO EDICAL HOSPITAL 1 Inpetient (Morning stigation 28s. PLA	E TO (eff AS A COR	EATH YILACE OF DEA	ES NO IN (Check only on OTHER: 4 Nursing No AE OF 28c. I JURY M 1	UNC UNC UNC VEX VEX VEX VEX VEX VEX VEX VE	ERTAIN aldence 6	PERT 1. 24a. WINS AI PERREC 1 YES	N AUTOPSY RMED? 2 100 1NJURY OCC	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES NO
ED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant of the cause of the c	c. Jou d. CONTRIBUTE TO EDICAL HOSPITAL 1 Inpetient (Morning stigation 28s. PLA	E TO (eff As A con ag to death but n ag to death	EATH YILACE OF DEA	ES NO IN (Check only on OTHER: 4 Nursing No AE OF 28c. I JURY M 1	UNC UNC UNC VEX VEX VEX VEX VEX VEX VEX VE	ERTAIN aldence 6	24a. WAS AI PERFO 1 YES Other (Specify) 88d. DESCRIBE NOW	N AUTOPSY RMED? 2 100 1NJURY OCC	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES NO
ETED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificant of the control of the cause of the	c. Jou d. CONTRIBUTE TO EDICAL HOSPITAL 1 Inpetient 28a. DAT (Morning integral on the bulk mined)	E TO (eff AS A COR	EATH YILACE OF DEA	In the underly ES NO ITN (Check only on OTHER: 4 Nursing No AE OF JURY M 1 atreet, factory, of	UNC Divine 5 UNC UNC UNC UNC UNC UNC UNC UN	ERTAIN aldenca 6	Other (Specify) Other (Specify) St. LOCATION (Street City or Town, State	INJURY OCC	URED Or Rural F	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES NO
ETED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificant of the county of the cause of the	c. Jou d. CONTRIBUTE TO EDICAL HOSPITAL 1 Inpetient 28a. DAT (Mor mined) 28a. PLA bulling	E TO (eA AS A COR	EATH YILACE OF DEA	In the underly ES NO ITN (Check only on OTHER: 4 Nursing N AE OF JURY M 1 atreet, factory, of	UNC a) UNC b) compared to the compared to	ERTAIN aldenca 6 NO 2 and due to	Other (Specify) Other (Specify) State City or Town, State the cause(a) and ma	INJURY OCC	URED OF Bural B	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
COMPLETED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificant of the county of the cause of the	c. Jou d. CONTRIBUTE TO DICAL HCSPITAL 1 Inpetient (Mor inherent ling stigation d not be mined 28a. PLA bulk	E TO (eA AS A COR	EATH YILACE OF DEA	In the underly ES NO ITN (Check only on OTHER: 4 Nursing N AE OF JURY M 1 atreet, factory, of	UNC b) me 5 control ta and placa, death occur	ERTAIN sidence 6 2 NO 2 and due to end at the time	Other (Specify) Other (Specify) Bd. DESCRIBE NOW St. LOCATION (Street City or Town, State the cause(a) and ma	INJURY OCC	URED or Rural Food.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO Route Number,
BE COMPLETED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant of the cause of the c	c. Jou d. CONTRIBUTE TO DICAL HCSPITAL 1 Inpetient (Mor inherent ling stigation d not be mined 28a. PLA bulk	E TO (eA AS A COR	EATH YILACE OF DEA	In the underly ES NO ITN (Check only on OTHER: 4 Nursing N AE OF JURY M 1 atreet, factory, of	UNC b) me 5 control ta and placa, death occur	ERTAIN aldenca 6 NO 2 and due to	Other (Specify) Other (Specify) Bd. DESCRIBE NOW St. LOCATION (Street City or Town, State the cause(a) and ma	INJURY OCC	URED or Rural Food.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
COMPLETED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant of the cause of the c	c. Jou d. CONTRIBUTE TO EDICAL HOSPITAL Ingestigation d not be mined 128a. PLA bulk	E TO (eff As A condition of the E TO (eff As A condition of the E TO (eff As A condition of the E OF INJURY and Ing., etc. (Specify) The E OF INJURY and Ing., etc. (Specify) The E OF INJURY and Ing., etc. (Specify)	EATH YI LACE OF DEA 28b. TIM II home, tarm,	In the underly ES NO ITN (Check only on OTHER: 4 Nursing No. AE OF JURY M 1 atreet, factory, of	UNC b) me 5 control ta and placa, death occur	ERTAIN sidence 6 2 NO 2 and due to end at the time	Other (Specify) Other (Specify) Bd. DESCRIBE NOW St. LOCATION (Street City or Town, State the cause(a) and ma	INJURY OCC	URED or Rural Food.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO Route Number,
BE COMPLETED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant of the cause of the c	c. Jou d. CONTRIBUTE TO EDICAL HOSPITAL 1 Inpetient 28a. DAT (Mornined 1997) Interest 1997 Interest	E TO (eA AS A COR	EATH YILACE OF DEAR 3 DOA 28b. Tilk IN. I home, tarm, I death occurr for investigation or k Rd	In the underly ES NO ITN (Check only on OTHER: 4 Nursing N AE OF JURY M 1 street, factory, of	UNC a) UNC b) compared to the control of the co	ERTAIN aldenca 6 NO 2 and due to ed at the times of t	Other (Specify) Other (Specify) Bd. DESCRIBE NOW St. LOCATION (Street City or Town, State the cause(a) and ma	INJURY OCC	URED or Rural Food.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO Route Number,

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DIVISION OF VITAL RECORDS,	
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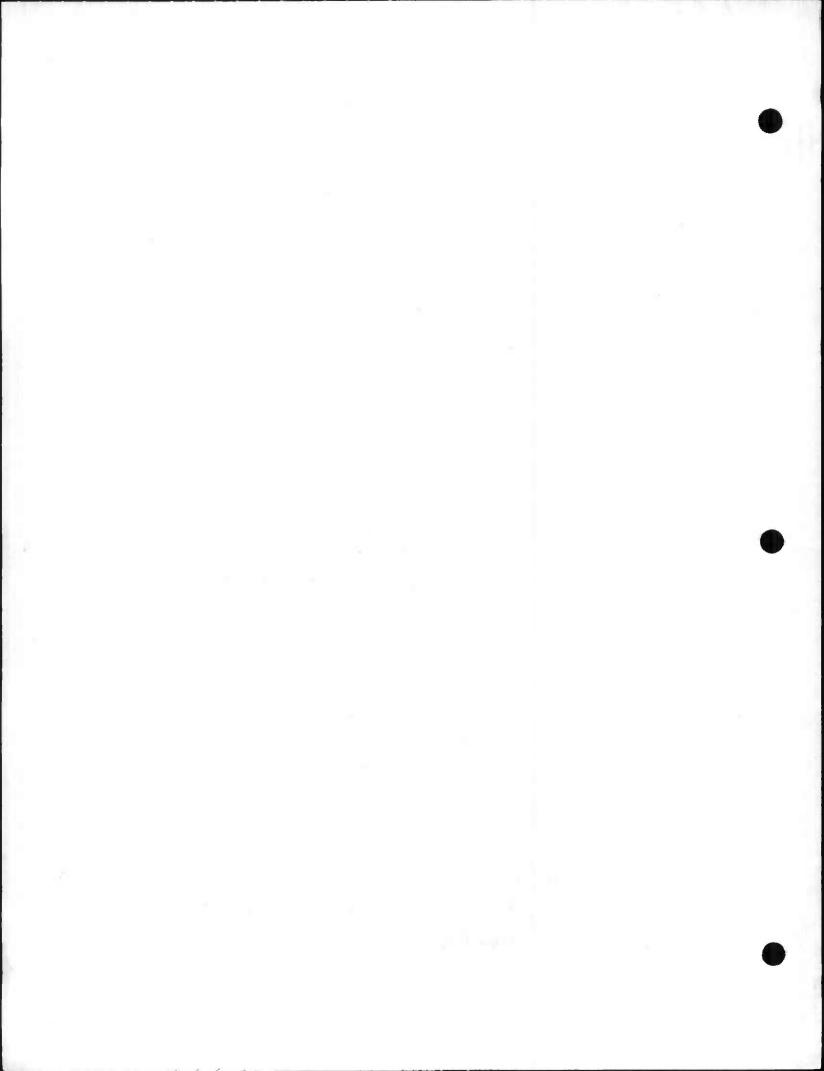
1995

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATN 3. TIME OF OFATN 140 July 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH B. BIRTNPLACE (State or Fo 20 t 🗌 M 2 😿 F 0 100 Pages 1, 2, 3 should 9e. FACILITY NAME (If not Institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Evergreen DIRECTOR 01 nns Daltimore NIH RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION tod. INSIDE CITY NA Himore 1 YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 19 Street OSher funeral director, page 5 should be detached for use as the burial-transit -16 retained by the hospital or attending physician, 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE -- American Indian, Black, White, etc. 1 Never Married 2 Merried If yes, specify Cuban, Mexican, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES 1 TES 2 THO Black BY Specify: 3. Widowed 4 Divorced Specify: COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY entary/Secondary (0-12) College (1-4 or 5+) 501 arade NA Home 17. FATHER'S NAME (First, Militale, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname F BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Stre or Rural Route Number, City or Town, State, Zip Code) 2 21216 within 24 hours after death. Page 6 may be 40 pe 20s. METNOD OF DISPOSITION
1 DEBuriel 2 Cremation 3 must 20b. PLACE AND DATE OF DISPOSITION / Name of DATE 20c. LOCATION -- City or Town, State val from State 7/13/2 4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF TUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY F. H. WOOD uron has been signed by the attending physician and completely filled in by the Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. 3 00 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heart failure. Liai only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition loh resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): Brain fyndrome executed traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A if any, leading to immediate death certificate be cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 6 injury, PART II. Other dualificant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert i. the MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO any COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? shows 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO UNCERTAIN I PHYSICIAN: MP 23 25. WAS CASE REFERRED TO MEDICAL The 26. PLACE OF DEATH (Check ofly one) Item this certificate h with the State I HOSPITAL OTHER: 1 TYES 2 -16 OR ATTENDING PHYSICIAN: Inpatient 2 ER/Outpatient 3 DOA 4 12 ng Home 5 - Residence 6 - Other (Specify) 6 27. MANNER OF DEATN 26e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO BY After 1 2 Accident 28e. PLACE OF INJURY — At home, farm, street, lactory, office building, etc. (Specify) 3 Suicide 99 E 8 Could not be 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: after 4 Nomicide 28 Ħ hours a Hem 29a. CERTIFIER 1 DCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. COMPL (Check only one) TO THE HOSPITAL
TO THE FUNERAL I
De filed within 72 h
IMPORTANT: If II 2 MEDICAL EXAMINER: On of exemination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end menner es stated. 29b. SIGNATURE AND TITLE O 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) mo 2 10 30. NAME AND ADD Frint) -APLETED CAUSE OF DEATH (ITEM 27) (Type, llen

les

JGNATHER

315



DIVISION OF VITAL RECORDS, P.O. BOX 68760

bospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Panes 1		nce.
24 hours after death. Page 6 may be retained b	y filled in by the funeral director, page 5 should I	tion, or removal.	the medical examiner must be notified
vires that the death certificate be executed within	signed by the attending physician and completely	Health and Mental Hygiene prior to burial, cremat	ws any injury, or other traumatic event,
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 6 may be retained by the hospital or attending physician.	NERAL DIRECTOR: After this certificate has been	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
TO THE H	TO THE FI	be filed w	IMPORT

2, 3 should

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	EALTH AND	MENTAL HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)		0711. 2 01	DEATH	2. DATE OF OEATH		3. TIME OF DEATH		
	Ocie Leatrice	Burns				July 11	1995	7:00 pm		
	4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	a, BIRTH	IPLACE (State or Foreign		
	94. FACILITY NAME (If not institution, give	1 M 2 K F	91 YAS.	MONTHS DAYS	HOURS MIN,	Ok1	ahoma			
DIRECTOR	Cherrywood Manor		1		CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Reisterstown Baltime					
[B	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN	TY	10c. CITY.	TOWN OR LOCAT	ION			104 MRIDE CITY		
		timore	I	Randalls			10d. INSIDE CITY LIMITS? 1 YES 2			
FUNERAL	10s. STREET AND NUMBER			101.	ZIP CODE	.1		WHAT COUNTRY?		
밀	4026 Cedar Mil				21133		U.S.A			
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 A NO		cify Cuban, Mexic	NIC ORIGIN? (Specify Yes or an, Puarto Rican, atc.)	No — 14. RACI Black Spec	E — American Indian, k, Whita, atc.		
D BY	3 Wildowed 4 Divorced 15. OECEDENT'S EO	UCATION	16a. DECEDENT'S U			16b. KIND OF BUSINI		White		
COMPLETED	(Specify only highest grad Elementary/Secondary (0-12)	(corrpleted) College (1-4 or 5+)	(Give kind of wo	vrk done durina mos	st of working	160. KIND OF BUSING	SS/INDUSTRY			
릊ㅣ	12	6	Teache	er		Element	ary Sch	ool		
ဂ္ဂ် ဂြ	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Middle, Maiden Sun	name)			
BE (William T. Cowl	ing			Nanc	y Elizabeth	Hale			
2	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Town, S				
-	Bootz Mercer		4026 0	Cedar Mi	lls Rd.	Randallstow	n, MD.2	1133		
1	20a METHOD OF DISPOSITION 1 Description 3 Ref	moval from State 20b	. PLACE AND DATE OF	DISPOSITION (Nar	me of		ION — City or To			
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L		rest Lawr				iottsvi	lle, MD.		
	A LL A	Sell 17			dt Fune	rak Chapel				
	J. Starks	askurdo		11605	Reisters	stown Rd. Ow	ings Mi	lls, MD. 211		
	23. PART I. Enter the diseeses, or shock, or heart failure	complications that cause List only one cause on e	I tha death. Do no ach iina.	t anter tha mod	da of dying, suc	ch as cardiac or reapirate	ory arrest,	Approximate interval Between		
	IMMEDIATE CAUSE (Finel	0	^	, 5	/	/ /-		Onset and Death		
ļ	disease Dr condition resulting in death)	a	your	nohu	1 en	funta		Instart		
_		DUE TO (OR AS A	CONSEQUENCE OF):	0.7		1.00				
RTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):		7	evene.	>	grace		
8	cause. Enter UNDERLYING CAUSE (Disease or injury	c						"		
띨	that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):							
CER	resulting in deeth) LAST	d,								
AL C	PART II. Other algolificant condition	ne contributing to deeth b	ut not resulting in	the underlying	ceuse given in	Part I. 24s. WAS AN AUT	TOPSY 24h	WERE AUTOPSY FINDINGS		
				, ,		PERFORME	D?	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
MEDIC						1 _ YES 2 _]	NO.	OF DEATH?		
	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YES	ПОП	UNCERTAI	N IO		1 TYES 2 TNO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH		OTTCERIAL					
SIC	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outp	atiant 3 DOA	OTHER:	5 Rasidence	6 Other (Specify)				
È	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. INJU	JRY AT	28d. DESCRIBE HOW INJU	RY OCCURED			
8	1 Natural 5 Pending 2 Accident Investigation	(MONIII, Day, Ibar)	INJUI		ES 2 NO					
E0 E	3 Suicide 6 Could not be	28a. PLACE OF INJURY building, atc. (Spec	— At homa, ferm, str	eet, factory, office		281. LOCATION (Street and City or Town, State)	Number or Rural F	loute Number,		
# 1	4 Homicide determined					City of lown, State)				
2	29a. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the best of my know	edge, death occurred	at the time, date	end place, end dua	to the cause(a) and manner	as stated.			
COMPLET	one) 2 MEDICAL EXAMIN	ER: On the beals of examination	end/or investigation,	in my opinion, de	ath occured at the	time, date and place, end de	ua to the cause(a) end manner as stated.		
иШ	296. SIGNATURE AND TITLE OF CERTIFIE	ER () - /			29c. LICENSE NUI	MBER 29	d. DATE SIGNED	(Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON W) ~	mo		D28	304 1	7/12	195		
	7 50 M	MA OF DE		rint)	- A	ad 21	136			
	31. DATE FILED (Month, Day, Year)	32, REGISTRAR'S SIGN	ATURE							
	JUL 1 8 1995 A	aly devolver has	tall							

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Deot, of Health and Mental Houlen prior to burial, cremation, or removal.

1 - STATE BEGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		TILOIOTTIAN				PLILIE.	CAIL	OI.	DEATH		REG. NO.			
		1. DECEDENT'S NAME (First,	Middle, Lest)								E OF DEATH		-	3. TIME OF DEATH
				Burdett						MON	1 /2		75	6:50 A "
		4. SOCIAL SECURITY NUMB 215-14-9248	ER	5. SEX	6. AGE (In yrs. la:	YRS.	MONTHS D	EAR MYS	HOURS MIN.	(Mon	of BIRTH th, Day, Year)		Count	HPLACE (State or Foreign ity) ryland
		9a. FACILITY NAME (If not ins	stitution, give at	reet and number)			9b. CITY, TO	DWN O	R LOCATION OF		124 190	9c. COU		
	R	LongView No	ursing	Home			Manchester				Carroll			
	DIRECTOR	RESIDENCE OF DEC	EDENT				redicties ter					00	2110	the Apr
		10a. STATE	10b. COUNTY			10c, CIT	Y, TOWN OR							10d. INSIDE CITY LIMITS?
		Maryland 100. STREET AND NUMBER	Carr	oTT			Har	_	tead					1 YES 24 NO
	IA I							101.	ZIP CODE					WHAT COUNTRY?
	FUNERAL	4606 Lynno	crest						21074				S.A	
		1 Never Merried 2	Married	12 WAS DECEDEN FORCES? 1	YES 2 K	NO	If y	98, spe	NDENT OF HISP city-Cuban, Maxis	can, Puerto	N? (Specify Yea Rican, etc.)	or No-	14. RAC Blac	E — American Indian, k, White, etc.
	ВУ	3 Widowed 4 Divor	rced	IF YES, GIVE V	MAR OR DATES		10] YES	2 M NO Spec	city:			Spec	White
	COMPLETED		EDENT'S EDUC highest grade		(G	ive kind of v	USUAL OCCI	JPATIO	N t of working	16	b. KIND OF BUS	INESS/IND	USTRY	
	E	Elementary/Secondary (0-	-12)	College (1-4 or 5	+) ///e	. Do NOT us	e retired.)				D			
eg G	N N	17. FATHER'S NAME (First, Min	Inteller 1 = Al			eTIE	mploye	a			Prod			
no n		Jeramiah St		Press.					16. MOTHER'S N			,		
Pel	BE	19a. INFORMANT'S NAME (IV		J	1 10	h MAII INC	ADDRESS (S		d Number or Rura					
notif	2	Leonora V.		an					Dr. Hai					
9		20e METHOD OF DISPOSITE					FDISPOSITION			DAT		CATION -		nun Stele
event, the medical examiner must be notified at once.		4 Donation 5 Other	(Specify)				t"Cem.		7-14-1			mpste		
nlne.	ij.	21. SIGNATURE OF FUNERAL	SERVICE LICE	ENSEE	17				ADDRESS OF F		D			
ехэ	- 70	Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester, MD. 21102											21102	
dica		23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate												
E		anock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death												
t,		disease or condition resulting in death)												
even					(OR AS A CONSE			7	1	,				
af	NO.	Sequentially list condition	one.		esper	ato	my	دلا	muff	rice	ny		Z	week
traumatic	F	If any, leading to immed cause. Enter UNDERLY!!	diata	DUE 10	OR AS A CONSE	DUENCE OF	7: 4	1	P	+	8			2
	윤	CAUSE (Disease Dr Injur		DUE TO	OR AS A CONSE	DUENCE OF	Jenu	_	ame	nhe				Lyn
or other	CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): C. End Stour Senil Rementia DUE TO (OR AS A CONSEQUENCE OF):												
Injury,		PART II Other significan	at assettitions		d45 5 4 4								_	
y In	DICAL	PART ii. Other algnificer	nt conditions	contributing to	deeth but not i	eaulting i	n the unde	rlying	ceuse given in	n Part I.	24s. WAS AN PERFOR		24b	. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
ws any	Ē										1 YES 2	NO		OF DEATH?
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8	SICIAN:	DID TOBACCO US		IBUTE TO CA			H (Check only		UNCERTA				\perp	
Item	SIC	EXAMINER?		HOSPITAL:			OTHER:		s □ 8					
0,0	PHY	27. MANNER OF DEATH		26s. DATE OF	INJURY	26b, TIM	E OF 28	c. INJU	5 Residence	1	SCRIBE HOW IN	LJURY OCC	CURED	
marked,	> 1		Pending nvestigation	(Month, D	ay, Year)	INJ	M M	WOR	K? ES 2 NO					
E	0 8	2 0 0 1 1 1	Could not be	26a. PLACE O	F INJURY — At he stc. (Specify)	me, farm, s	treel, factory,	offica		28f. LOC	ATION (Street a	nd Number	or Rural I	Route Number,
1 28	EE		letermined	Dullottig,	are (opecity)					City	or Yown, State)			
Hem	MPLE	29a. CERTIFIER (Check only	FYING PHYSIC	IAN To the best of	my knowledge, de	ath occurre	d at the fime	, date a	end place, and du	n to the ca	use(s) and man	ner as state	ed.	
NT: H	COM													i) and manner sa stated.
HA	w II	296. SIGNATURE AND TITLE	OF CERTIFIER	4					29c. LICENSE NU	JMBER		29d. DATE	E SIGNED	(Month, Day, Year)
IMPORTANT:	0 8	W.H	Frow						DO23	86		17	/12,	95
		30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	223 M	M 27) (Type,	Print) 5+	UA	NeLo	cto	r M	/ 7	110	2_
		31. DATE FILED (Month, Day, Y		32 REGISTRA	R'S GNATURA	200	//	171		3/	1 110	112	,// 0	
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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within A hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defacthed		IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	THE STREET	letely	be filed writhin 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	mt,
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	FOR STATE REGISTRAR	STATE OF I	MARYLAND C	DEPAR	TMEN	T OF H	EALTH	AND I		HYGIEN REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last)							-	2. DATE OF				3. TIME OF DEATN	
	DORIS BUCZEK									MONTH DAY YEAR				
	4. SOCIAL SECURITY NUMBER	5 SEX	6. AGE (In yrs. le	(In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.					7. DATE OF		95		11:14 A M	
	219-050979	1 M 2 F	7.5	YRS.	MONTHS	DAYS	HOURS	MIN.	12-13	3-19		MARY	LAND	
	Sa. FACILITY NAME (If not institution, give st	treel and number)			9b. CIT	Y, TOWN C	R LOCATIO	ON OF DE	-	, 1)	9c. COU	NTY OF DE		
OR	EASTPOINT NURSING	HOME					TIMO					ALTIM		
<u>ا</u> ي	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	T												
DIRECTOR	MARYLAND BALTI		10c. CIT	Y, TOWN	OR LOCAT	ION NDALF	ζ.				- 1	10d. INSIDE CITY LIMITS7 X 1 YES 2 NO		
4	10e. STREET AND NUMBER					10f.	ZIP CODE				10a, CITI		HAT COUNTRY?	
FUNERAL	1949 WAREHAM ROAD					21	222					sa		
3	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AI	RMED	13.	WAS DEC	ENDENT O	F NISPAN	HC ORIGIN? (Specify Yes			- American Indian	
F	1 Never Married 2 Married	FORCES? 1 IF YES, GIVE W	YES 2.	NO		If yes, spe	elfy Cubar	n, Mexica	n, Puerto Rici	n, atc.)		Black,	— American Indian, White, etc.	
8√	3 Wildowed 4 Divorced					. [] .20	-20,110	эроспу	,.			WHI	TE	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	18a. Di	ECEDENT'S	USUAL C	CCUPATIO	N et of workin	~	16b. KI	ND OF BUS	INESS/INC	DUSTRY		
9	12 YEARS	Cotlege (1-4 or 5		ive kind of Do NOT u		during mo.	n or working	9	V.	-MART				
MP			100	MULL	LEA					TARKI				
	17. FATHER'S NAME (First, Middle, Last) ELLWOOD BROWN						18. MOTH	ER'S NA	ME (First, Mide LSER	die, Maiden	Surname)			
8														
6	19a. INFORMANT'S NAME (Type/Print) MRS. ANGELINE DIB	LASIO	18	949 W	AREH	S (Street at	OAD 1	or Rural F	O. MD	City or Town	1, State, Zip	Code)		
	20a. METNOD OF DISPOSITION		20b. PLACE						DATE			City or Tow	2012	
	1 Buriel 2 X Cremetion 3 Remo	oval from State	GREEN				ne oi		1	ALTO		-	n, State	
	STUDIONATURE OF FUNERAL BENNIOS LIC	ENSEE	CICLERA	11001			D ADDRES	S OF FA				•		
1	160111 200	John an	Court						UNERAI					
9	-10000 PM	FRUM	COLLEY	1					AVENUI				1222	
	23. PART I. Enter the diseased, of c ahock, or heart failure. I	lat only one cau	coused the de se on each line	eath. Doi a.	not anter	the mod	de of dyle	ng, aucl	h aa cerdiad	or reapli	ratory arr	reat,	Approximata Interval Batween	
	IMMEDIATE CAUSE (Final disease or condition	0	0	100	4								Onset and Death	
- 1	resulting in death)	. Cardy	Kerli	HKK	ese								10-15 min	
_		of DA.	1 A R	M	-):)	00		0	16	7 %			0	
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	OR AS A CONSE	OUENCE O	2:	Ch	would	Re	nel of	aelu	مه		3+ Jm.	
F	cause. Enter UNDERLYING	Dene	tra	2	ch	2004	ie.	Dos	meter	h-			2.44	
Ē	CAUSE (Disease or injury that initiated events	PUE TO	OR AS A CONSE	OUENCE OF	·):								24 /2.	
F	reaulting in death) LAST	Keci	rest	u	lo.	- Se	eles	1 7					14	
ū	DART II Other significant condition		death by a second			/						1	1	
MEDICAL	PART II. Other algnificant conditions	contributing to	daeth but not	resulting	n tha ui	nderlying	cause g	iven in	Part I. 24	PERFOR		1	WERE AUTOPSY FINDINGS WAILABLE PRIOR TO	
ă									1	☐ YES 2	NO		COMPLETION OF CAUSE OF DEATN?	
Σ											O	1	TES 2 NO	
Z	DID TOBACCO USE CONTR	RIBIJTE TO CA				NO N	UNC	ERTAIN	1 🗆 📗	11.61				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		CE OF DEAT	N (Check									
Z S	1 YES 2 NO	1 Inpatient 2		,	4 🕅 Nu	wing Home		Idence	8 Other (S	pecify)				
	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF (Month, D	(NJURY y. (Nar)	28b. TIM INJ	E OF URY	28c. INJU WOI	PIC7		28d. DESCR	BE HOW IN	JURY OCC	CURED		
B	2 Accident Investigation	200 PLACE A	F INJURY — At he		M		ES 2 _	NO						
8	3 Suicide 8 Could not be 4 Homicide detarmined	building,	etc. (Specify)	ине, тегт, г	RIBBE, IBC	tory, office			281. LOCATION OF T	ON (Street as own, State)	nd Number	or Rural Ro	ute Number,	
E I	29a. CERTIFIER					_	_		_					
COMPL	(Check only	TO the best of	my knowledga, da	ath occurr	ed at the t	Ime, date	and place,	and due	to the cause(e) and man	ner aa stat	ed.	and manner as stated.	
8			manufactur.		or in my s	grinnin, de		-		ptace, and	stue to th	e cause(s)	and manner as stated.	
BE	296. SIGNATURE AND TITLE OF GERTIFIER		7				THE LICE			Ī			Month, Day, Year)	
9		COMPLETED CAUS	01				J'	72	-2/			1.7	.95	

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

T. A. T. ROZVI 2. 2. 5 BASTERN BLUS

31. DATE FILED (Month, Day, Year)

JUL 1 3 1995 July 32 DEGIS FAR'S KNAJURE

JUL 1 3 1995 July 32 DEGIS FAR'S KNAJURE

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MARYLAND 21215-0020 BALTIMORE,

BOX 68760 DIVISION OF VITAL RECORDS,

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Butcher Mary July 7, 1995 1:14 A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. 8. BIRTHPLACE (State or Foreign 7. DATE OF BIFTTH (Month, Day, Year) May 6, 1933 216-30-6680 1 M 2 62 Maryland Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR 1920 Nevil Road Dundalk Baltimore. 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Dundalk 1 TES 2 NO permit. FUNERAL 104 STREET AND NUMBER 10g, CITIZEN OF WHAT COUNTRY? the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit Mental Hygiene prior to burial, cremation, or removal. 1920 Nevil Road 21222 United States hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS OCCENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NNO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried specify: White BY 3 Widowed 4 Divorced COMPLETED 16a. DECEOENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5 +) 12 Years Title Clerk Clerk Automotive. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) notified at John Schuncke Marie Stodder 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 George P. 1920 Nevil Road Dundalk, Maryland must be 20e. METHOD OF DISPOSITION
1 Disposition 3 Removel from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE complete, cremetory or other place!
Hilltop Service Corp. 7/10/95 4 Donation 5 Other (Specify) Towson, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such ea cardiec or respiratory arrest, medical Approximate shock, or heert failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Finel Onsat and Death the diseese or condition HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 of cancer resulting in death) traumatic event, DUE TO (DR AS A CONSEQUENCE OF) net asiases CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury dehydration DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMEO?/ been signed by ti shows any 1 YES 2 NO DF GEATH? 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO I UNCERTAIN A 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h HOSPITAL: OTHER: 1 YES BY NO □ Inpetient 2 □ ER/Oulpatient 3 □ DOA 4 Nursing Home 5 Beeldence 6 Other (Specify) 20 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED Natural 5 Pending м 1 YES 2 NO DIRECTOR: After the hours after death v BY 2 Accident 28e. PLACE OF INJURY — At home, Ierm, strest, lectory, office building, etc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 60 COMPLETED 6 Could not be 4 Homicide 28 Hem CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, dete end place, end due to the cause(e) end manner ee stated.

MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. TO THE HOSPITAL OF THE FUNERAL DE FILED WITHIN 72 h (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

31. DATE FILEO (Month, Day, Year, 3 1995

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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DIVISION OF VITAL RECORDS, P.O. BOX 687

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Ariours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYL		IENT OF HEALTH A		AL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last)				2. DA	TE OF DEATH		3. TIME OF DEATH
	LOLA BRUMBER	G			, T11	Ly 6, 19		6:00 P M
. 1	4. SOCIAL SECURITY NUMBER 5.	. SEX 6. AGE (/	In yrs. lest birthday)	UNDER 1 YEAR IF UNDER 24	HRS. 7. DAT	TE OF BIRTH	6. BIRT	HPLACE (State or Foreign
	075-20-8642	□ M 2 🖾 F 9		NTHS DAYS HOURS I	mint.	onth, Day, Year)	Coun	(ry)
	9e. FACILITY NAME (If not institution, give street			CITY, TOWN OR LOCATION		2. 14.	896 Po	Land
DIRECTOR	Hebrew Home Of Gr			Rockville			Montg	
H	10a. STATE 10b. COUNTY		10c. CITY, T	OWN OR LOCATION				10d. INSIDE CITY LIMITS?
	Maryland Montg	omery		Rockville				1 X YES 2 NO
AL	10e. STREET AND NUMBER			101. ZIP CODE			10g. CITIZEN OF	WHAT COUNTRY?
TER.	6105 Montrose Roa	d		20852			USA	
FUNERAL		2. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DECENDENT OF H			or No — 14. RAC	E - American Indian,
ВУ	1 Never Merried 2 Married 3 Niver Microsoft Mi	IF YES, GIVE WAR OR DA		1 TES 2 THO		to ricall, atc.)	Spe	olly:
	15. DECEDENT'S EDUCAT	T						White
COMPLETED	(Specify only highest grade con	npleted)	(Give kind of work life. Do NOT use re	done during most of working	1	16b. KIND OF BUS	INESS/INDUSTRY	
2		College (1-4 or 5 +)		mou.)				
M	17. FATHER'S NAME (First, Middle, Last)	2 Yrs	Nurse	40 MOTHER	DIO MANE (E)	Medic		
	4					t, Middle, Malden	,	
BE	(Unknown) Bronen 19a. INFORMANT'S NAME (Type/Print)		10h MANINO AD	DRESS (Street and Number or		ı) (Unkn		
2	CONTRACTOR OF THE PROPERTY.							
	Abraham Brumberg	205	PLACE AND DATE OF D	adley Lane.	Chevy	Chase.	Maryland ATION - City or 1	1 20815
	28s. METHOD OF DISPOSITION 14 Buriel 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	from State	etery, crematory or other	place) 7/1 pital Hebrew	0/1995	200. LOC	ATION — City of I	own, State
	21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE INA	fional Cap	DITAL Hebrew	Cemet	ery va	DITOT H	eignts, MD
	Donald C.	Statte	muck	STEIN HEBRE 232 CARROLL	W MEMO	DRIAL FU W, WASH	NERAL HOLLINGTON,	DME, INC. DC 20012
	23. PART I. Enter the diseases, or com	plicationa that caused	the death. Do not	enter the mode of dying	j, auch as ca	ardiac or reapli	atory arreat,	Approximata
	shock, or heart failure. List IMMEDIATE CAUSE (Final		11124		Λ Λ	1 = (1	_ 1.	Onset and Death
	disease or condition reaulting in death)	>CN(CE	OCME	NTIAOL	- H	L2HE	IMERS	14R 154 GARS
.,	_	DOE TO (ON AS A	CONSCIOENCE OF):					
CERTIFICATION	Sequentially list conditions, If any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):					
PAT	cause. Enter UNDERLYING			-				
Ĕ	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):					
	resulting in death) LAST							
	PART ii Other significant annulisiana	votribution to death t	ut and assisted to			1	201	
SA	PART ii. Other significant conditions c	wantening to death be	or not reauting in t	na underlying cause give	en in Part i.	24a. WAS AN A PERFOR		b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă						1 TYES 2	000	OF DEATH?
Σ								1 - YES 2 - NO
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIB				RTAIN 🗆			
2	EXAMINER?	OSPITAL:	28. PLACE OF DEATH (PHER:				
1×S	1 TYES 2 NO 1	28e. DATE OF INJURY	etlent 3 DOA 4	Nursing Home 5 - Reald	_			
	Natural 5 Pending	(Month, Day, Year)	28b. TIME O	WORK?		DESCRIBE HOW IN	JURY OCCURED	
B	2 Accident Investigation	280 DI ACE OF IN HIDY	44 54 54 54 54 54 54 54 54 54 54 54 54 5	M 1 YES 2 N				
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, atc. (Speci	— at nome, term, atre- ify)	π, ractory, office	281. LC	OCATION (Street a ity or Town, State)	nd Number or Rural	Floute Number,
<u> </u>	29a, CERTIFIER X							
MP	(Check only VI) CERTIFYING PHYSICIAL			t the time, date and placa, an				
COMPLET		// trie seels of examination	and/or investigation, is	n my opinion, death occured	at the time, da	ata and place, end	dua to the cause	s) and manner es stated.
BE (29b. SIGNATURE AND TITLE OF CENTIFIER	() () () ()	atten	ing 29c. LICENS	SE NUMBER	1	29d. DATE SIGNE	O (Month, Day, Year)
2	10	D account	J Physica	SIC PARS	508	<u> </u>	JULY	07.1995
	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEA	-	(1)	1.1.	1.1-	4 2	
	1). 1). PATELL	0121 IVION	TROSE	KO KOC	KUI	LLE 1	41) 2	0832
	31. DATE FILED (Month, Day, Year)	A STEELEN CONTRACTOR	PIDGE					
	1117 I 4 1000							

	rmit. Pages 1, 2, 3 should		
uted within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	r use as the bi		If Hom 28 is marked or Hom 23 shows any injury or other traumatic event the medical examines must be notified at once
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after death	y the fune	moval.	ical evar
\$ hours	lled in b	n. or rer	pem e
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ITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed	RAL DIRECTOR: After this certificate has been signed by the attending physician and	saith and Mental Hygiene prior to burial	other
e death	he aften	Wental F	ומרע מו
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ATTEN	CTOR	s after	28
IL OR	L DIRE	Phoun.	Hem
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 JUANITA Motie COOK July 9:55 P. 4. SOCIAL SECURITY NUMBER !. SEX 8. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 - M 2 X F 9a. FACILITY NAME (If not institution, give street and numb 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Maris DIRECTOR timore 10WSon Bal DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? timore 1 YES 2 NO FUNERAL 10s. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3909 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yea. specify Cuben, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 TES 2 NO BY Specify: 3 Widowed 4 Divorced ETED 15. DECEDENT'S EDUCATION ecity only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ve kind of work done Do NOT use retired.) NA or 5+) th grade COMPL Clark 05 17. FATHER LAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Sum liams BE ANNABELL MURRAY 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS WALTER COOK 2 3909 KIMBLE RD, 20a. METHOD OF DISPOSITION

1 Surial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Nat DATE 20c. LOCATION -- City or To 7-14-95 ☐ Donation 5 ☐ Other (Specify) tar (OF FUNERAL SERVICE LICENSEE 21. SIGNATU 22. NAME AND ADDRESS OF FACILITY March Funeral Home Wes 4300 Wabash Avenue 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximete** IMMEDIATE CAUSE (Fine Onset and Dasth disease or condition UNG CANCER Gnes resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO PHYSICIAN: UNCERTAIN X 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL QTHER:
4 Muraing Home 5 Residence 6 Other (Specify) 1 TES NO Inpetient 2 - ER/Outpetient 3 - DOA 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending investigation 1 YES 2 NO BY 2 Accident 26a. PLACE OF INJURY — At home, term, street, tectory, office building, atc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide determined 29a. CERTIFIER
(Check only Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(a) and manner as stated. I MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date end place, and due to the ceuse(s) and manner as stated. TO THE HOSPI TO THE FUNEF be filed within 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) aullellins 3564 95 10 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD. , TOWSON, MD 21204 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 1995

1	FOR STATE REGISTRAR	STATE OF N	MARYLAN	D / DEPAR CERTIF	ICATE	OF DEATH	D MEI	REG. NO					
	1. DECEDENT'S NAME (First, Middle, Last)			gene Co		Sr.	1 1	DATE OF DEATH WONTH July 5,	1995	YEAR	3:30 P		
	4. SOCIAL SECURITY NUMBER 232-18-9411	S. SEX	6. AGE (In y	s. lest birthday) YRS.	MONTHS	AYS HOURS ME	M	Month, Day, Year) JULY 21.	1918	Countr	IPLACE (State or Foreign y) t Virgini		
CTOR	9a. FACILITY NAME (If not institution, give s 2700 Gray Manor RESIDENCE OF DECEDENT					ndalk	F DEATH		9c. COUN		imore		
DIREC	10a. STATE 10b. COUNTY	Y		10c. CIT	Y, TOWN OR						10d. INSIDE CITY LIMITS?		
4 1	Maryland 100. STREET AND NUMBER	Baltim	ore			101. ZIP CODE	undo	ilk	10g. CITIZ	EN OF V	1 YES 2 X NO		
LONEH	2700 Gray Manor 11. MARITAL STATUS	12. WAS DECEDEN				DECENDENT OF HIS		RIGIN? (Specify Ye		14. RACE	ed States		
	1 Never Married 2/C/ Married 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE W			1 [es, specify Cuban, Ma YES 2 TY NO S		erto Rican, etc.)		Speci	white, atc. White		
	15. DECEDENT'S EDU- (Specify only highest grade Elementary/Secondary (0-12)			(Give kind of life. Do NOT u	work done dur	IPATION ng most al working		18b. KIND OF BU	SINESS/IND	USTRY			
COMPLET	12 Years 17. FATHER'S NAME (First, Middle, Last)			Elect	ionics		NAME (F	A C First, Middle, Maider	LOS pa	ce			
	Ottie Anderson (Carder		405 4441 1916	1 1000500 (Lul	a Be	ell Stew	art		<u> </u>		
2	Mrs. Lucille D.	Carder		2700	Gray						nd 21222		
	20s. METHOD OF DISPOSITION 1 D Burlel 2 Cremation 3 Ram 4 Donation 8 Other (Specify)	oval from Stata	cemeter	ACEAND DATE y, cremetory or c LU HILL	ther place)	Gdns 7/	1		$\frac{1}{2}$		wn, State 1. MD		
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE			22. NA DU	da⇔Ruck F	uner	ral Home	of Di	unda	lk, Inc.		
1	23 PART Enter the diseases, or consplications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, App												
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	L	ina	1	NOW	rima					Onset and Da		
	resulting in death)	L L	(OR AS A.CO	HISEOUENCE O	n:	TO A NINA					140-10		
HIIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	. 24	OR AS A CO	NSEQUENCE O	Lyuc	pulmi	me	y obs	truci	tin	5 yrs		
뜅	PART (Cother stepitions) condition	d.	4-45-5-4							_			
MEDICAL	PART ii. Other algnificant condition	a contributing to	death but r	ot resulting	In the unda	riying ceuse given	in Part	t. 24a. WAS AN PERFO	RMED?	24b.	WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
AN	DID TOBACCO USE CONTI	RIBUTE TO CA		DEATH YI			AIN [1 TYES 2 NO		
္ဗ	1 YES 2 NO	HOSPITAL:	ER/Outpaties	51	OTHER:	Home 5 Residen	ics 8 🗆	Other (Specify)					
ВУ РНУ	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF (Month, Di		28b. TIN	URY	c. INJURY AT WORK?	28d	DESCRIBE HOW	NJURY OCC	URED			
	3 Suicide 6 Could not be determined	28a. PLACE O building,	F INJURY — / stc. (Specify)	At home, ferm,	street, factory	offics	281.	LOCATION (Street City or Town, State	and Number	or Rural A	loute Number,		
COMPLE						, data and place, and) and manner as stated		
2	296. SUMATORE AND TITLE OF CERTIFIER					29c. LICENSE		7/			(Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUS	SE OF DEATH	(ITEM 27) (Type	Print)	1001	107	22	-//	6/	75		
	31. DATE FILED (Morth, Day, Year)	32. REGISTRA	R'S SIGNATUI	LOCK!	to.	MUX	1040	XON					
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STATE	OF MARYLAND / DEPARTMENT			NTAL HYGIENE
R	CERTIFICATE	OF DEAT	ГН	REG. NO.

		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAI CERTIF	RTMENT OF	HEALTH AND	MENTAL HYGIE					
		1. DECEDENT'S NAME (First, Middle, Last) Eugene	Donald	Davis			2. DATE OF DEATH	DAY 199	3. TIME OF DEATH			
		4. SOCIAL SECURITY NUMBER		yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign			
10		219-22-0187	1X M 2 D F	5 YRS.	MONTHS DAYS	HOURS MIN.	April 6,		Country) Maryland			
should	_	9a. FACILITY NAME (If not institution, give at				OR LOCATION OF D	EATH	9c. COUNTY				
1. 2. 3	DIRECTOR	Johns Hopkins Ba		ctr.	Balt	imore Ci	ty	N,	/A			
permit, Pages		10a. STATE 10b. COUNTY Maryland 10a. STREET AND NUMBER	Baltimore	10c. CiT	Y, TOWN OR LOCA	Dunda	lk		10d. INSIDE CITY LIMITS? 1 YES 2 NO			
sit	FUNERAL	11 Waterview Roa	d		10	of. ZIP CODE	222		ited States			
020 physician. burial-transit	O.	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1XXYES		13. WAS DE	CENDENT OF HISPA	NIC ORIGIN? (Specify Y		RACE - American Indian			
P 2 2	BY F	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR OAT		1 CT VE	S 2 NO Speci	en, Puerto Ricen, etc.) /y:		Black, White, etc. Specify: White			
	TED	15. DECEDENT'S EDUC (Specify only highest grade	ATION completed)	16a. DECEDENT'S	USUAL OCCUPATI	ION lost of working	16b. KIND OF B	USINESS/INDUS				
N º Þ	PLET	Elamentary/Secondary (0-12) 6 Years	College (1-4 or 5+)	Me. Do NOT u	se retired.)			Todo +	: a 0			
AND 2 the hospital detached to once.	COMPL	17. FATHER'S NAME (First, Middle, Last)		ELL	ctricia		AME (First, Middle, Maide	Indust	ual			
3 6 A	I	Eugene Davis				Inez 1	Anderson					
MAR retained to 5 should notified	5	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or To					
	1 1	20a. METHOD OF DISPOSITION	200.5		1880 Nati			pt. D Edgemere, MD 21219 ATE 20c. LOCATION - City or Town, State				
TE E E		1 Buriel 2 Cremation 3 Remo	val from State come	tery cremetory or c	ther place!		11/95 T					
		21. SIGNATURE OF PUNERAL SERVICE VICE	INIES	MANUF -	22. NAME A	ND ADDRESS OF FA	CILITY HOM	a of Du	indalh Tuo			
- L		5811	2	22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk In 7922 Wise Ave. Dundalk, MD 21222								
In by remic		23. PART L Enter the diseasea, or co shock, or heart fallure. L	omplications that caused list only one ceuse on each	the death. Do					, Approximata			
filled ion, or the m		IMMEDIATE CAUSE (Finei				164			Interval Between Onset and Death			
ompletely il, cremat		reaulting in death)	CANCE	CONSEQUENCE O	5 TI	HE L	UNG		3 YEARS			
scuted of computation	z				,							
OX OX of the control	AT	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	OUE TO (OR AS A C	CONSEQUENCE O	F):							
ifficate physiene price	FI C	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A C	CONSEQUENCE O	F):							
death certificate attending physiental Hygiene print, or other to	CERTIFICATION	resulting in death) LAST										
9 4 5 E	AL C	PART II. Other aignificent conditions	contributing to deeth but	t not resulting	in the underlyin	ng ceuse given in	Part i. 24e. WAS A	N AUTOPSY	24b. WERE AUTOPSY FINDINGS			
that the same	SCA	CHRONIC OBST					PERFO	PRMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
비 공 은 는 현	MEDICA						1 _ YES	7,010	OF DEATH?			
S ept. b	AN:	DID TOBACCO USE CONTR					N 🗆					
- F 2 2 5	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:		TH (Check only one) OTHER:		VIII	-				
SICIAL Certiff h the	HY	27. MANNER OF DEATH	1 ☐ Inpatient 2 ☐ ER/Outpat	28b. TIM	E OF 28c. IN.	JURY AT	8 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCUR	ED			
DING PHYS After this death with	ВУР	Netural 5 Pending Investigation	(Month, Day, Year)	IN.		YES 2 NO						
TTENDI TTENDI TOR: A after de		3 Suicide 6 Could not be determined	26s. PLACE OF INJURY – building, atc. (Specif)	At home, farm,	street, factory, offic	20	281. LOCATION (Street City or Town, State	and Number or F	Rural Ploute Number,			
10日本の日	COMPLETE	29a. CERTIFIER (Check only one) CERTIFYING PHYSIC	IAN: To the best of my knowled	dge, death occurr	ed at the time, data	and place, and due	to the cause(s) and mi	inner as stated.				
HOSPITAL FUNERAL WITHIN 72	1 11	29b. SIGNATURE AND TITLE OF CERTIFIER	: On the basis of examination :	and/or investigation	n, in my opinion, c							
TO THE HOSPI TO THE FUNER be filed within	BE (Dece	Suth			29c. LICENSE NUI	3417	29d. DATE SI	GNED (Month, Day, Year)			
FFA	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEAT	Н (ІТЕМ 27) (Туре		, , ,	510 /	1.00	110-113			
180		201 Wise F	the	Ballin	on M	10	91993					
100		"JULI"3"1995" / Ju	A. REGISTRAR'S SIGNAT	URE M								

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		C	:KIIFI	CALE	F DEATH	F	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF	DEATH	•	3. TIME OF OEATH	
	SHIRLEY	DONNEC					MONTH	DAY	YEAR		
1 1	4. SOCIAL SECURITY NUMBER						July			3:15 P	M.
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (in yrs. las	t birthday)	MONTHS DAY		7. DATE OF I (Month, De		8. BIRT	HPLACE (State or Foreign	77
	130-22-4406	1 □ M 2√√F	63	YRS.	MONTHS DAY:	HOURS MIN.		25, 193		w York	
	9a. FACILITY NAME (If not institution, give	street and number)			96 CITY TOW	N OR LOCATION OF C			DUNTY OF		\dashv
œ							- CATTI	30.0	JONIII OF	DEATH	- 1
DIRECTOR	Anne Arundel Med	<u>ical Cente</u>	r		Ann	apolis		A	nne A	rundel	
ပ္ပ	10e. STATE 10b. COUN	TV		I so out	TOWN OR LO						
E		11		10c. Cr11	, IOWN OR LO	CATION				10d. INSIDE CITY LIMITS?	
ā	Maryland Ann	e Arundel			Annapo	lis				1 TYES 2 NO	
1	100. STREET AND NUMBER MASTLINE					10f. ZIP CODE		10g. C	TIZEN OF	WHAT COUNTRY?	
E	1020 Mastune Dri	***				01/01					- 1
FUNERAL	11. MARITAL STATUS					21401	191		US		
교	1 Never Married 2 Married	12. WAS OECEDENT FORCES? 1	YES 2	MED	13. WAS D	ECENOENT OF HISPA specify Cuban, Maxic	UNIC ORIGIN? (S en. Puerto Rice	pecify Yes or No- n. etc.)	14. RAC Black	E — American Indian, ck, White, atc.	
BY	3 Widowed 4 Olvorced	IF YES, GIVE W	AR OR DATES			ES 2 NO Speci			Spe		
										White	_ 1
ETED	15. DECEDENT'S ED (Specify only highest gra-		16a. DE	CEDENT'S	JSUAL OCCUPA	TION	16b. KIN	O OF BUSINESS	INDUSTRY		
	Elementary/Secondary (0-12)	College (1-4 or 5+	life.	Do NOT use	ork done during retired.)	most of working	ŀ				
ᆸᆸ	12 Yrs			retai	-77		111 6	. Gover			
COMPL	17. FATHER'S NAME (First, Middle, Last)		1 360	retar	. У	T		e, Maiden Surname			-
						16. MOTHER S N.	AME (FIRST, MICO	e, Maiden Surnami	1)		- 1
出	Harry Jenkin					Mirian	n Coope	r			
2	19a. INFORMANT'S NAME (Type/Print)		190			et and Number or Rural	Route Number, (City or Town, State,	Zip Code)		
=	Charles Dondes		1	020	ASTLINE Sactume	Drive, A	nnanol	is Mar	brefv	21/01	
	20a. METHOD OF DISPOSITION		20h PLACE	NODATEO	E DISPOSITION	(Name of	DATE	20c 1 OCATION	- City or 1	own State	\neg
	1 St Buriel 2 Cremetton 3 Ra 4 Donation 5 Other (Specify)	movel from State	cemetery, cre	matory or oth	ner place)	(Name of 7/10/1	1995	73 - 7 7 -	Ol.	_1	
	21. SIGNATURE OF FUNERAL SERVICE I	.00110.00	King D	<u>avıd</u>		al Garder		ralls	Chur	ch, Virgin	nla
	21. SIGNATURE OF FUNERAL SERVICE	JCENSEE			STET	AND AGORESS OF F	ACILITY MEMOR T	AT FINE	DAT 11	OME, INC.	- 1
1	Venala (1 Stor	theme								- 1
	22 PART I Fater the diseases of				232	CARRULL S	o1, NW,	WASHIN	GIUN,	DC 20012	_
	23. PART I. Entar the diseases, or shock, or heart failure	. List only one ceu	se on sech line	eth. Do n	ot antar the	noda of dying, su	ch as cardiac	or reepiratory	arrest,	Approximate interval Batw	
	IMMEDIATE CAUSE (Final									Onset and De	
	disease or condition	ጀ ተ፣ ለጥሮ	RAL PNE	TIMONIT						İ	
	reaulting in death)		OR AS A CONSE								-
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CERTIFICATION	Sequentially list conditions,	bENDOME	TRIAL C	ARCIN	OMA, M	ETASTATIO	;				_
E	if any, leading to immediate	DOE TO	ON AS A CONSE	DUENCE OF):					1	
호	cause. Enter UNDERLYING CAUSE (Disease or injury	c									
논	that initiated events	DUE TO	OR AS A CONSEC	DUENCE OF):						- 1
	reculting in death) LAST	d									
EDICAL	PART ii. Other aignificent condition	ons contributing to	death but not r	esulting in	tha underly	ing causa given in	1 Part I. 24	PERFORMED?	Y 24	b. WERE AUTOPSY FINDIP AVAILABLE PRIOR TO	NGS
일	MYCOSISFUNGO	DIDES					11	YES 2 NO		COMPLETION OF CAUS	SE
	DEHYDRATION						[' '	J 125 2X NO		OF DEATH?	
Σ	DID TOBACCO USE		TO CALIS	E OE	DEATH	VEC CI NO				1 NES 2 NO	- 1
PHYSICIAN:		CONTRIBUTE	TO CAUS	L OF	DEATH	YES NO	2 23		_		
8	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:				PLACE OF OEATH (C	heck only one)				
Š	1 TYES 2 NO	1 2 Inpetient 2	ER/Outpatient 3	□ DOA	OTHER: 4 - Nursing H	ome 5 🗆 Residence	8 Other (Sc	necify)			
<u></u>	27. MANNER OF DEATH	28a. DATE OF		28b. TIME	- T	NJURY AT	Y	BE HOW INJURY	CCUBEO		
	1 🔀 Natural 5 🗌 Pending	(Month, Da	y, Year)	INJ	PRY	WORK?	200. 020011		JOGOTED		
B	2 Accident Investigation					YES 2 NO					_
8	3 Suicide 8 Could not b	28a. PLACE Of building,	INJURY — At ho itc. (Specify)	me, farm, a	reet, factory, o	fica	281. LOCATIO	N (Street and Num wn, State)	ber or Rural	Route Number,	
	4 Homicide determined						1000	,			
ובו	29a. CERTIFIER 1 1 CERTIFYING PHY	SICIAN: To the best of	mu knowladaa da		4 -4 44 - 44 - 4						\neg
물											
COMPLET	Z MEDICAL EXAMI	VER. On the basis of ax	amination and/or	riveatigation	i, in my opinior	, death occured at th	e time, data and	place, and due to	the cause	(a) and manner as state	d.
BE C	29b. SIGNATURE AND TITLE OF CERTIFI	ER				29c. LICENSE NU	MBER	29d. 0	ATE SIGNE	O (Month, Day, Year)	\dashv
	n Clan	M.B.	MPH	-		D38328	3			7, 1995	
유	30. NAME AND ADDRESS OF PERSON W				Print)	230320			July	1, 2000	
1 1											
	M Clanna M D	MIDIT 100	A 1 0 -								
	M. Clance M.D.			Coch	rance	Drive, Ar	napoli	s, Mar	yland		
	M. Clance M.D. 31. DATE FILED (Month, Day, Year) JUL 1 3 1995		Admiral	Coch	rance	Drive, Ar	mapoli	s, Mar	yland		

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

F VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020	hours after death, Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should thit estate Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within riours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, crismation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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	1 _ STATE		ARTI A	RNII /	DEPAR	TMFN	I OF H	FAITH	AND B	MENTAL	HYGIEN	E		
	REGISTRAR		mairi e					DEAT		WENTAL	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)										F DEATH			3. TIME OF DEATH
	BEATRICE C.	EACKLOFF								монтн .Т11.Т з	- O 1	1995	YEAR	3:476
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (I	n yrs. last	birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE Č	F BIRTH	771	6. BIRTH	IPLACE (State or Foreign
	042-18-1693	1 □ M 2 🏝 F		79	YRS.	MONTHS	DAYS	HOURS	MIN.		Day, Year)	1915	Countr	w York
	9a. FACILITY NAME (If not institution, give st	rent and number)		, ,		9b. CITY	, TOWN C	R LOCATIO	ON OF DE		7 14,		NTY OF D	
Œ	403 Hinsdale Lan					C ± 1	***	Const						
DIRECTOR	RESIDENCE OF DECEDENT	<u> </u>				211	ver	Spri	ng			IV)	ontg	omery
Ĭ,	10a. STATE 10b. COUNTY				10c. CIT	Y, TOWN	OR LOCAT	ION						10d. INSIDE CITY
	Maryland Mon	tgomery			S	ilve	r Sp	ring						1 YES 2 NO
FUNERAL	10e. STREET AND NUMBER							ZIP CODE				10g. CIT	IZEN OF V	VHAT COUNTRY?
EH	403 Hinsdale Lan	e						2090	1				USA	
	11. MARITAL STATUS	12. WAS DECEDEN				13.	WAS DEC	ENDENT O	F HISPAN	IIC OBIGIN?	(Specify Yes	or No —	14. RACE	- American Indian.
	1 Never Merried 2 Married	FORCES? 1 IF YES, GIVE W			0		If yes, spe	2 Q NO	n, Mexicar	n, Puerto Ri	cen, etc.)		Black Speci	c, White, etc.
B	3 🖾 Widowed 4 🗌 Divorced						. [] .20	×	ороспу					White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	ATION Councileted		16a. DEC	EDENT'S	USUAL O	CCUPATIO	IN .		16b.	KIND OF BU	SINESS/INC		
n	Elementary/Secondary (0-12)	College (1-4 or 5	·)					st of workin	g					
Ĭ		4 Yrs		Bio	Che	mist				H	oward	Univ	ersi	.ty
5	17. FATHER'S NAME (First, Middle, Last)							16. MOTH	IER'S NAI	ME (First, Mi	iddle, Maiden	Surname)		
	Louis Kantor							Est	her	Movs	howit:	Z		
20	19a. INFORMANT'S NAME (Type/Print)			19b.	MAILING	ADDRES	S (Street a	nd Number	or Rural F	Route Numbe	r. City or Tow	n. State. Zir	Code)	
2	19b. INFORMANT'S NAME (Types/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10608 John Ayres Drive, Fairfax, Virginia 2203													00000
	Talliax Virginia //U3/													
	20s. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 7/11/1995 Adelphi, Maryland													
	21. SIGNATURE OF FUNERAL SERVICE LIC	FNSEF	Trio	unc	TEDS			D ADDRES		CH LTV	Ad	етри	L, 1	daryrand
	Donald C	Stat	77	_,,,	. h	S.	CEIN	HEBR	REW N	MEMOR				DME, INC. DC 20012
Ť	23. PART I. Enter the diseases, or c	omplications the	t ceused	Me dae	eth. Do r	not enter	tha mo	de of dvi	ng. auch	h aa cardi	ac or read	ratory an	rest.	Approximate
	ahock, or heart failura. I	isl only one csu	ise on ea	ich lina.				,						Intarval Between
	IMMEDIATE CAUSE (Final disease or condition	ar	+-	•	_		1.1		محلم	+	D	_		Onset and Deal
	reaulting in death)		(OR AS A				mcc.		ACC		الساء	500	20	years
		DOE 10	(UH AS A	COMSEO	UENCE O	۲):								,
5	Sequentially list conditions,	DUE TO	(OR AS A	CONSEC	LIENCE O	n.								
	If any, isading to immediata cause, Enter UNDERLYING	502 10	(On AS A	CONSEC	UENCE U	-):								i
2	CAUSE (Disease or injury	DUE TO	(OR AS A	CONSEC	HENCE O	D.								
EHILICALION	that initiated events reaulting in dasth) LAST	502 10	(011 75 7	CONSEC	DENCE O).								
בו כ		1		-										
	PART ii. Other significant condition	contributing to	death bu	ut not re	suiting	n tha ur	nderiying	cause g	Ivan in	Part I.	24a. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDING
MEDICAL											PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
3			_							-	1 YES 2	NO		OF DEATH?
	DID TOPLECO LIST O	CALITAINIE		C 1 1 1 C		DEAS	P1.1 3.6		110					1 YES 2 NO
	DID TOBACCO USE C	ONTRIBUTE	: 10	CAUS	E OF	DEA			NO				\perp	
rn isleidi.	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:				OTHE		ACE OF DE	EATH (Che	eck only one)			
2	1/XYES 2 NO	1 [] Inpetient 2 [atient 3		4 🗆 Nur		5 KR	aldence	6 🗆 Other	(Specify)			
5	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF (Month, D			28b. TIM	URY	28c. INJI WO	JRY AT RK?		28d. DE\$0	RIBE HOW I	NJURY OC	CURED	
5	1. Natural 5 Pending 2 Accident Investigation					M		'ES 2 [NO					
	3 Suicide s Could not be	28e. PLACE O building,	F INJURY etc. (Speci	— At hon	ne, farm,	stree1, fac	tory, office				TION (Street I		r or Rural F	Route Number,
3	4 Homicide determined										,			
:	29a. CERTIFIER (Check only 1 CERTIFYING PHYSIC	CIAN To the best of	my knowle	edge, des	th occum	ed at the t	lme, date	and place.	and due	to the caus	e(a) and mar	nner aa ata	ted.	
0.														a) and menner as stated.
N N	MEDICAL EXAMINE													
COMPLEIED	2/OLMEDICAL EXAMINE		400	-2 n										
200	29b. SIGNATURE AND TITLE OF CENTIPIER			~				29c. LICE		IBER	1			(Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

8 21 8

32 REGISTRAR'S SCHATURE

31. DATE FILED (Month, Day, Year)

JUL 1 8 1995

CD (5 CA

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

TOROGENET NAME (Print, MARC) AND AND AND AND AND AND AND AND AND AND	REGISTRAR CERTIFICATE OF DEATH REG. NO.
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2 □ Wilderseet 1 □ Difference	10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?
2 □ Wilderseet 1 □ Difference	114 S. BOULDIN STREET 21224
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